

Class Journal No.

GIFT

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

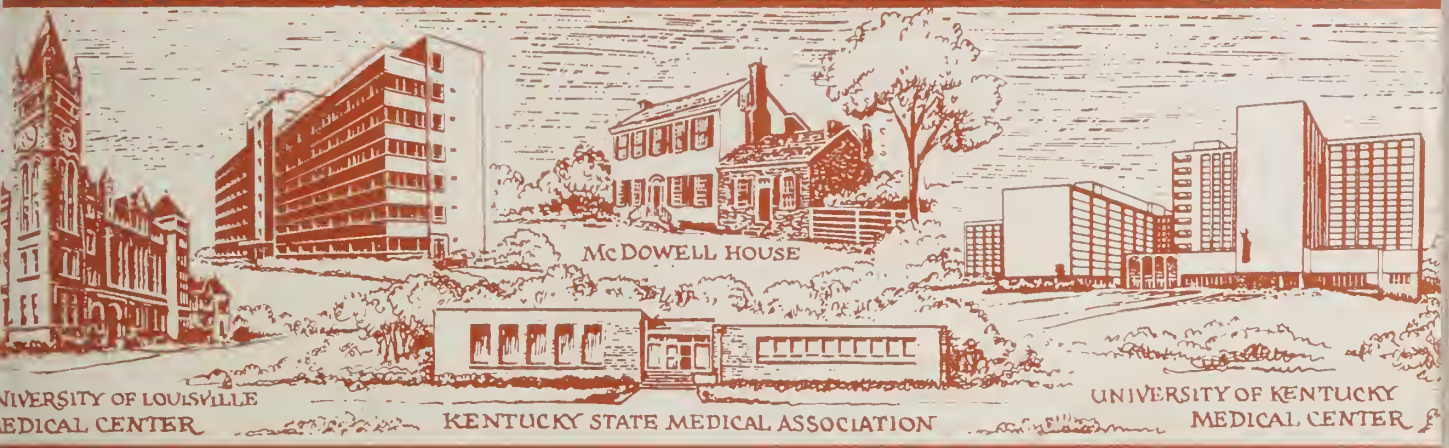
Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofkentuck6219kent

JANUARY 1964 • VOLUME 62 • NUMBER 1

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JAN 22 1964

Disaster Medical Care Issue

including . . . . .

Kentucky Updates Disaster Care Program

Latest Advances in Scientific Procedure

Physician's Role is More Significant

Emergency Hospital Coverage Extended

Complete contents on page 4

KSMA Interim Meeting April 23

Jenny Wiley State Park, Prestonsburg, Ky.


Helps to make the epileptic's life more meaningful
Dilantin Kapseals
(Diphenylhydantoin sodium)
Effective in control of grand mal and psychomotor seizures, this agent enables the epileptic patient to lead a useful life.
Indications: Grand mal epilepsy and certain other convulsive states. Precautions: Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia has been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.
PARKE-DAVIS



Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced.[1-2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality."[1] *Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients.* Rautrax-N is effective in mild,[3] moderate,[3,4] or severe hypertension.[4,5]

Dosage: Initially, 1 to 4 tablets daily preferably at mealtime. For maintenance, 1 or 2 tablets daily.

Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycosuria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin® [Rauwolfia serpentina whole root], 4 mg. Naturetin® [bendroflumethiazide], and 400 mg. potassium chloride. *Rautrax-N Modified*—50 mg. Raudixin [Rauwolfia serpentina whole root], 2 mg. Naturetin [bendroflumethiazide], and 400 mg. potassium chloride, in capsule-shaped tablets. For full information, see your Squibb Product Reference or Product Brief.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

SQUIBB
Squibb Quality
—the Priceless Ingredient
SQUIBB DIVISION Olin

RAUTRAX®-N RAUWOLFIA SERPENTINA WHOLE ROOT (50 MG.), BENDROFLUMETHIAZIDE (4 MG.) WITH POTASSIUM CHLORIDE (400 MG.), SQUIBB

235008 APR 26 1967

VOLUME 62 • January 1964

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR

Som A. Overstreet, M.D.

• ASSOCIATE EDITOR

Wolter S. Coe, M.D.

• MANAGING EDITOR

J. P. Sanford

• ASST. MANAGING EDITOR

Ann M. Huntsmon

• DEPARTMENTAL EDITORS

Jack L. Chumley, M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscar J. Hayes, Case Discussions
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR

George F. Brockman, M.D., Chairman
Willett H. Rush, M.D.
Blaine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Moore, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1966

Harold L. Bushey, M.D.
Edward J. Fodell, M.D.
Merle W. Fowler, Jr., M.D.
Joseph L. Goldstein, M.D.
John D. Lovett. M.D.
George F. McAuliffe, M.D.
Ralph G. Thomas, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965

McHenry S. Brewer, M.D.
Lewis Dickinson, M.D.
Zygmunt Gierlach, M.D.
Douglas L. Gillim, M.D.
Arthur H. Keeney, M.D.
James B. Stith, M.D.
Chester B. Theiss, M.D.
Kearns R. Thompson, M.D.

Term Expires July 1, 1964

Herbert L. Clay, Jr., M.D.
Orville T. Evans, M.D.
M. Randolph Gilliom, M.D.
John Gardinier, M.D.
Franklin B. Moosnick, M.D.
William Oldham, M.D.
Howard W. Ripy, M.D.
Samuel M. Smith, Jr., M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205

Subscription $8.00—single copy .80

Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

Emergency Medical Services Issue: Introduction
William T. Rumage, M.D., Special Editor 19
Governor's Letter
Edward T. Breathitt, Governor of Kentucky 19
AMA Activity in Disaster Medical Care
Max L. Lichter, M.D. 20
Medicine, Government, and Disaster Planning
Gabriel P. Ferrazzano, M.D. 22
Chemical, Bacteriological and Radiological Warfare
Joseph D. Stokes, M.D. 24
Civil Defense Disaster Plans for Kentucky
Col. Leon J. Reed 31
Evacuation and/or Shelters—When and Where in Ky.
Lt. Col. Louis J. Hackett, Jr., M.C., U.S.A. 32
Emergency Health Services in Kentucky
Russell E. Teague, M.D. 34
The Civil Defense Emergency Hospital in Kentucky
Frank Reider, M.D., and Forrest Stokes, A.B. 36
You, Your Hospital, and Disaster Planning in Kentucky
Ben R. Brewer and William B. Haley 38
The Red Cross and Disaster Planning
Darrell House 40

FEATURES

Medical Education for National Defense 42
Disaster Committee Reports from Ky. Counties 44
Flying Physicians to Assist in Emergency 45
Emergency Medical Identification for Special Problems .. 46

CASE DISCUSSION

A Lupus-Like Syndrome Following Propylthiouracil Administration
Maurice M. Best, M.D., and Charles H. Duncan, M.D. 47

EDITORIALS

Medicine's New Dimension 50
Gobble-De-Gook! 51
Research Espionage 51

SPECIAL ARTICLES

KSMA's Statement on King Anderson Bill
Gaithel L. Simpson, M.D. 53
Responsibility
Mrs. J. Murray Kinsman 54

ORGANIZATION

Dr. Nyaradi Will Address KSMA At Interim Meeting 58
Membership Award Given KEMPAC in Portland 58
Kentucky Well Represented in AMA House of Delegates 59
Congress on Mental Health Set May 14 in Louisville 59
KSMA Members Now More Active in AMA Posts 59
"Hypertension" is Topic of January 23 Seminar 59
Digest of Actions of AMA House at Portland Meeting 60
Senators and Representatives Listed for 1964 Session 64
Dr. Ling Named New Chairman of Radiology at U. of L. 69



For peptic ulcer gastric hyperacidity and gastritis...

In year-long study on peptic-ulcer patients

New Creamalin®
Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off.

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

Winthrop LABORATORIES New York 18 N Y

MESSAGE FROM THE PRESIDENT



Disaster Medical Care

A HUNDRED years ago the words "Disaster Medical Care" would probably have had little meaning, if any, to those who may have heard or read them. Today, however, because of our highly populous nation and the great achievements in scientific technology, they have not only become a familiar phrase but a challenge to our profession.

None of us condone conflict or desire to witness the tragedy of nuclear war, earthquakes, or any devastating acts of nature; yet it befalls the responsibility of every individual physician to be knowledgeable of and plan for such disastrous situations. As we work constantly to maintain freedom, we must at the same time educate ourselves in the field of "Disaster Medical Care" and assume a cooperative and leading role in community planning.

You will recall reading in the newspapers on November 1 of last year, when in nearby Indianapolis, an explosion the night before at the Fairgrounds Coliseum killed 64 persons and injured 385 others. When and if any similar situation strikes Kentucky, we too must be prepared to render medical aid quickly, efficiently, and without chaos.

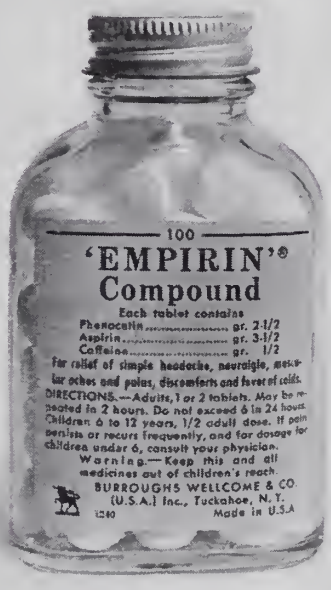
I take pride in expressing my sincere appreciation to the members of our Emergency Medical Services Committee for their many hours of hard work in preparation of this special issue of the Journal on "Disaster Medical Care." I hope each of you can keep it as a ready reference in your personal library.

George O. Archer M.D.



Regardless
of the antibiotic
or sulfonamide
you prescribe...

remember
'Empirin'
Compound
to relieve
pain and
lower fever



Also: 'Empirin'® Compound with Codeine Phosphate*
gr. ⅛—No. 1/gr. ¼—No. 2/gr. ½—No. 3/gr. 1—No. 4
*Warning—may be habit forming

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses

NEW MEN'S SHOP

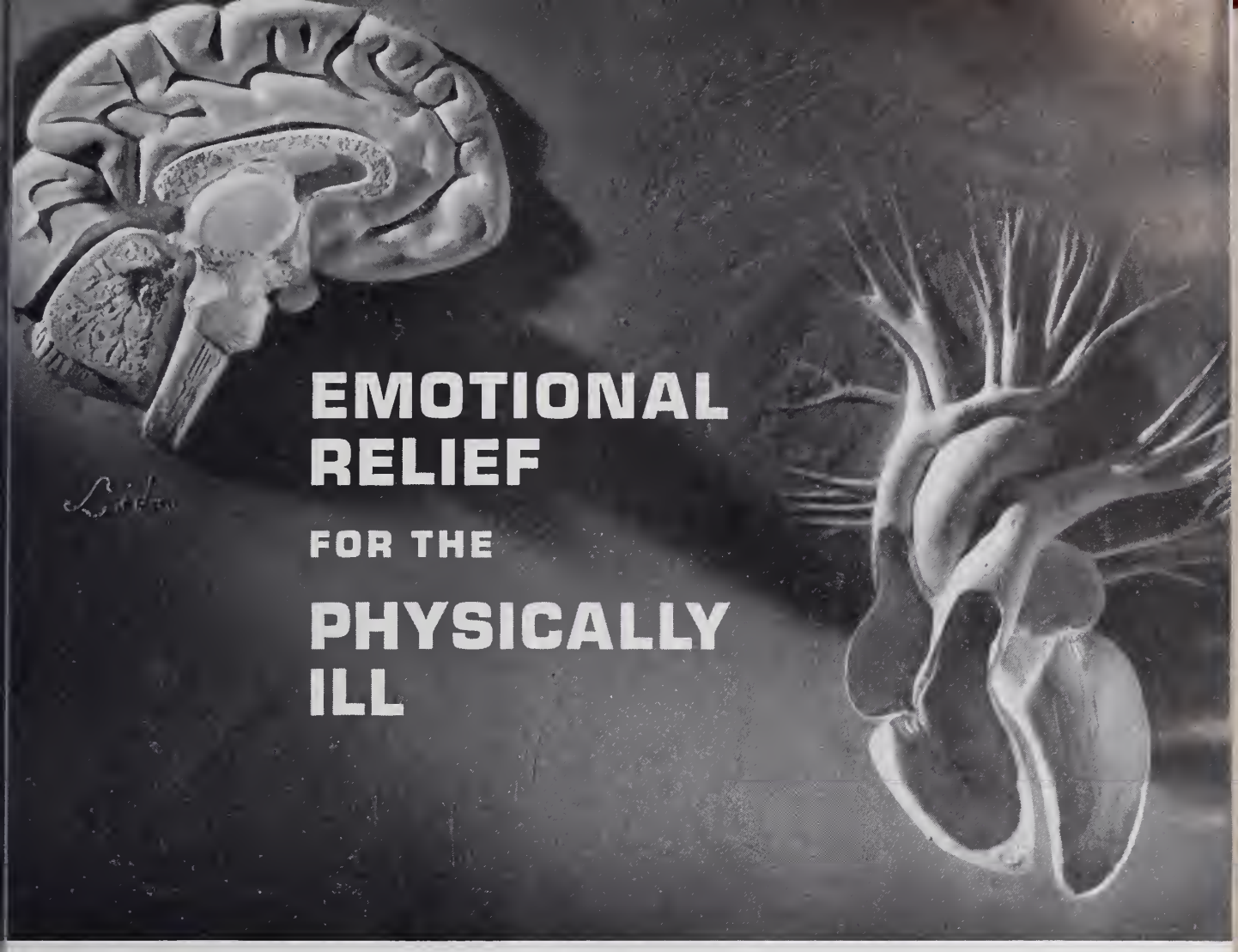


. . . in our **NEW SOUTHERN OPTICAL BUILDING**, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

GUILD OPTICIANS

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th



RELIEVES ANXIETY, APPREHENSION AND TENSION...



All day long

. . . keeps the patient calm, and the mind clear.



All night too

. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400

(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CME-760

WALLACE LABORATORIES *Cranbury, N. J.*

PUBLIC HEALTH PAGE

Maternity Care*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health, Commonwealth of Kentucky

MATERNITY care has been provided to Kentucky women through local Health Department Clinics for many years whenever they couldn't obtain prenatal or postnatal care by a private physician. These clinics are held usually at the local Health Departments by the Health Officer or by private physicians from the community with the assistance of public health nurses and other Health Department personnel. Not all local Health Departments have set up prenatal and postnatal clinics, but maternity care is given in all in a different range. Physician care of pregnant women throughout the years as well as the rates of hospital deliveries have increased steadily. By 1962, 94.6% of deliveries in Kentucky took place in hospitals.

The need for comprehensive maternity care is accepted by all and this service was started in 1963 in two eastern counties (Harlan and Bell), with surplus funds from Children's Bureau. The project of care for women in these areas includes periodic prenatal and postnatal examinations by qualified physicians from the community, hospitalization for deliveries in authorized hospitals, follow up visits by public health nurses prior to and after delivery and payment of drugs and tests prescribed by the physicians. Comprehensive maternity care throughout the state could reduce maternal morbidity and mortality to a minimum. An index that points to the usefulness of these programs is the fact that maternal mortality is still preventable in many cases.

Many steps to improve maternity care has been taken and will be taken in all directions until an optimum is reached. One such step was taken a few years ago by the Kentucky State Medical Association when an active Statewide Maternal Mortality Committee was created to review all maternal deaths, follow the trends in causes and give recommendations when needed. The program of this Committee, headed now by Barton L. Ramsey, Jr., M.D., Somerset, will undoubtedly be an asset in the reduction of maternal deaths through it's educational objectives, by setting standards of obstetrical practices, and by encouraging needed facilities in hospitals.

Maternity care as a health endeavor includes the training and licensing of midwives, still practicing in many areas where their need is obvious because of shortage of physicians, lack of hospital facilities, etc.

Another step taken in the last few years by many local Health Departments, especially in the eastern part of the state, have included family planning activities as an integral part of their programs. It is encouraging to see that more emphasis has been given lately to these programs and more understanding of its need has been apparent among health workers, the medical profession in general, and the public.

These and other steps of the medical profession to combat maternal morbidity and mortality (including research), the improvement of hospital facilities, educational programs directed at the communities to show them the need and advantages of prenatal and postnatal care and the establishment of comprehensive maternity care program for all women, with special attention to the ones in the "high risk" groups, will undoubtedly diminish maternal as well as infant mortality and will increase the number of healthy mothers and babies with a future to look for. Prevention of many diseases, disabling conditions and death, through good maternity care, is a challenging health problem.

* *This article was prepared by Jorge Deju, M.D., M.P.H. Director Maternal, Infant & Preschool Services Division of Maternal and Child Health, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky.*



release for hostility?

Overeating is often an outlet for feelings of hostility. Many people take out their anger by overindulgence at or between meals. As a result they become overweight.

'Eskatrol' *Spansule* capsules both control appetite and relieve the emotional stress that causes overeating. That's why so many patients are losing more pounds with 'Eskatrol'.

ESKATROL® Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

SPANSULE®

brand of sustained release capsules

because emotions play an important role in overweight

Brief Summary of Principal Side Effects and Cautions

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory. *Cautions:* 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

For complete prescribing information, please see *PDR* or available literature.

Supplied: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F

IN THE BOOKS

PERSONNEL IN WORLD WAR II: Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, Surgeon General of the U.S. Army. Editor-in-Chief, Col. John B. Coales, Jr., M.C., U.S.A.; Published by the Government Printing Office, Washington, D.C., 1963; 548 pages; price, $6.00.

This volume discusses in full detail the many large problems encountered in the procurement, assignment and classification of Medical personnel during World War II. The impact of increasing the number of Medical officers in the armed forces from 1500 in 1940 to 50,000 by the war's end is a major theme. The role of the nation's Medical Schools is illuminated. The reader also sees the difficulties encountered because of the initial lack of coordination between the various procurement agencies. Redevelopment, retraining and demobilization of professional personnel is described in great detail.

This volume is well designed for staff officer study because of the large amount of data which is presented in meticulous detail. As a planning guide for future medical mobilization and as a reference source the book is beyond reproach.

Donn L. Smith, M.D.

CECIL-LOEB TEXTBOOK OF MEDICINE: edited by Paul B. Beeson, M.D., and Walsh McDermott, M.D.; Published by the W. B. Saunders Company, Philadelphia and London, 1963; 1835 pages; price, $19.50, single volume; $23.50, two-volume set.

In the preface to the first edition of this standard textbook of medicine, published in 1927, Russell Cecil, M.D., stated the guideline that has resulted in the remarkable acceptance of this book by medical students and practitioners throughout the years. He pointed out that the rapid growth of medical science has made it impossible for a single individual to master the entire field of medicine and proposed a textbook written by 150 investigators recruited from the ranks of teachers of medicine in medical schools. Each contributor was selected on the basis of active investigation in the area of his special interest. The present edition, the eleventh, continues this format; of the 173 contributors, essentially all are medical educators. In the 36 years since the first edition, the book has grown larger by 750 cubic centimeters, heavier by 1.49 kilograms, and contains 395 more pages.

Just as it has become impossible for a single author to write such a volume, it is equally impossible for a single physician to critically review a work of this magnitude. Several generalizations might be permitted. The size of the single volume makes it difficult to read; distribution of the 4 kilograms of reading material in the two-volume set would seem to be worthwhile. It is generally well written with less of the irregularity in literary style that is common in books of multiple authorship. The index is adequate and permits the finding of a fascinating array of subject material ranging from A-beta lipoproteinemia to zona.

Several annoyances were encountered. Many of the illustrations, figures and formulae add little to the text. Surprisingly, the section on skin diseases, where the usual physician is most apt to need visual aid in his diagnosis, is without illustrations. Additional references should be added in many areas to permit exploration of the subject matter in the medical literature. The tables of "normal" laboratory values are of limited usefulness since the responsible laboratory methods are not stated.

In my opinion, several of the introductory sections are outstanding and should be read and reread by student and physician alike. I recommend the section on arterial hypertension by Perera, headache by Wolff, and heart failure by Stead as provocative and useful discussions of these common problems of medical care. My own prejudice suggests that the section on atherosclerosis should be expanded and brought up to date since the most recent of the seven references is 1960.

The volume is highly recommended as a good place to *begin* the study of medicine.

Maurice M. Best, M.D.

HANDBOOK OF THE PRACTICE OF ANESTHESIA: by John R. S. Shields, M.B. Published by The C. V. Mosby Company, St. Louis, 1963; 203 pages; price, $6.85.

Doctor Shields has presented in a concise and easily read book a safe and sensible way of administering anesthesia. The book is on a student, intern, resident level and, as such, stresses the most important points as far as safety is concerned.

In a book of this type, Chapter 2, on the preparation for anesthesia, is perhaps the most important. The author presents in detail the equipment necessary for the conduct of a safe anesthetic and for the control of any unexpected situation.

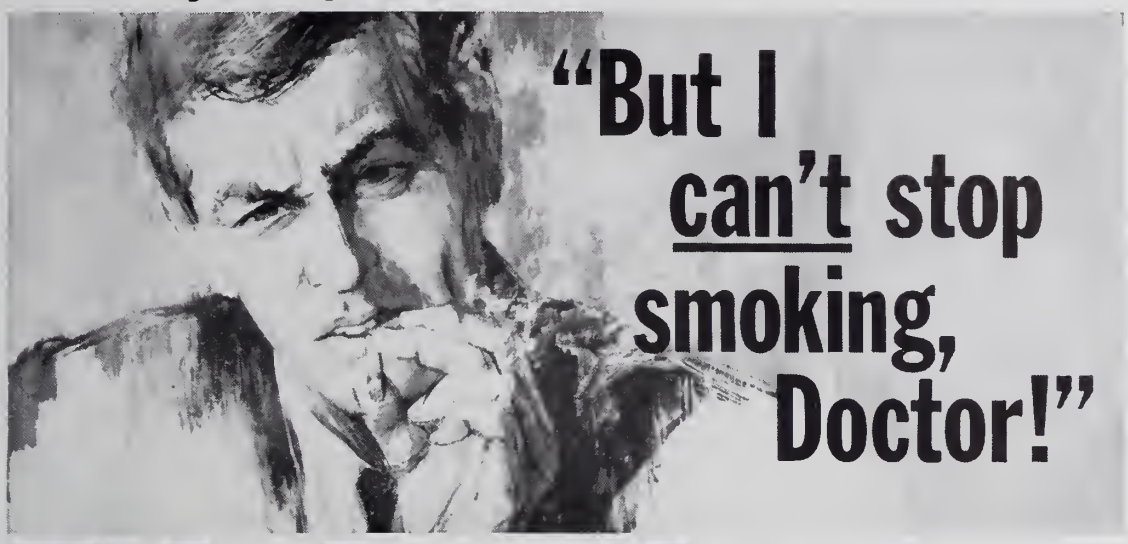
Parts 2 and 3 contain information on techniques in anesthesia all of which are pertinent and helpful to individuals unfamiliar with the situations presented. The section on unusual problems associated with anesthesia will be helpful to those beginning anesthesia training or those occasionally doing anesthesia by its recognition of the conditions that present problems.

Part 5 relates to its reader the problems arising in the postoperative period in which the anesthesiologist may help the patient.

This book's value is in relating not only the do's in safe anesthesia but, more important, the don't's.

W. Neale Bennett, M.D.

When your patient says:



Nikoban® PASTILLES

BRAND OF LOBELINE SULFATE, MRT

help curb the smoking habit

- Help induce a feeling of satiety similar to that of tobacco because of lobeline's pharmacological relationship to nicotine.
- Permit the patient to indulge his oral fixation by substituting the NIKOBAN Pastille for tobacco.
- Utilize the anorexic effect of lobeline to help the patient who is driven to compulsive eating when he discontinues smoking.
- Encourage patient cooperation through pleasant taste.

Dosage and Administration: In order to obtain the maximum benefit, a NIKOBAN Pastille should be sucked slowly and taken according to the schedule below. Whenever possible a pastille should be taken after meals.

1st week: 1 pastille every 1 to 2 hours for a maximum of 12 pastilles daily. *2nd week:* 1 pastille every 3 hours. *3rd week:* 1 pastille every 4 hours. *4th week:* 1 pastille every 4 to 6 hours. *Thereafter* 1 pastille may be taken at infrequent intervals whenever necessary. In some instances there may at first be a slight astringent burr of the tongue and throat. This will usually disappear as treatment with NIKOBAN Pastilles progresses and is no cause for concern.

Caution: It is advisable neither to smoke nor to use a smoking deterrent during pregnancy.

Formulation: Each NIKOBAN Pastille contains 0.5 mg. lobeline sulfate in a pleasant tasting spiced-cherry base.

Availability: In packages of 50 pastilles.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, Macmillan, 1960, Ed. 2, pp. 620-622; 2. Edmunds, C. W.: J. Pharmacol. and Exper. Therap., 1:27, 1909; 3. Hazard, R. and Savini, E. Gand., 92:471, 1963. 4. Dorsey, J. L.: Ann. Int. Med., 10:628, 1936; 5. Rasmussen, K. B.: Ugeskr.laeger, 118:222, 1956; 6. Ejrup, B.: Sven. lak. Tid., 53:2634, 1956; 7. Jochum, K. and Jost, F.: Munch. med. Wchnschr., 103:618, 1961; 8. Jost, F. and Jochum, K.: Med. Klin., 54:1049, 1959; 9. Smoking and Health, Summary and Report of the Royal College of Physicians of London on Smoking. New York, Pitman, 1962.

M. R. THOMPSON, Inc., Medical Department- BB
711 Fifth Avenue, New York, New York 10022

Gentlemen:
Please send me a trial supply of NIKOBAN Pastilles.

NAME _____ M.D.

ADDRESS _____

CITY _____ ZONE ____ STATE _____

TYPE OF PRACTICE _____

M. R. THOMPSON, INC. • NEW YORK, NEW YORK 10022



who were the "untreatables"?

From their inception with cortisone, to the present-day variants of the steroid molecule, the corticosteroids have presented a therapeutic paradox. The beneficial action against inflammation and allergy as well as several undesirable metabolic effects are all, apparently, the results of the same basic physiologic action.[1]

Some of these associated metabolic reactions made it risky or otherwise undesirable to treat with steroids large numbers of patients in various categories who would otherwise have benefited from such management. These "untreatables" were overweight, had cardiac disease, hypertension, or pulmonary fibrosis associated with congestive heart failure. Also in this category were those patients whose emotional symptoms were aggravated by earlier steroids.

But the advent of ARISTOCORT® Triamcinolone in 1958—the result of biochemical and pharmacologic research which successfully stripped away many important undesirable hormonal effects from the primary anti-inflammatory action—dramatically changed this picture. This steroid did not overstimulate the appetite, or cause the excessive weight gain induced by other steroids;[2-7] it proved to have one of the best records of any steroid for *not* causing edema, or salt-and-water retention;[2,3,7-10] and the incidence of undesirable euphoria with this agent was remarkably low.[2,4,5,9,10] What is most significant is that these benefits have stood the test of more than 5 years of widespread use. And, of course, the avoidance of these distressing hormonal effects benefited *all* patients requiring steroids, not just those in the special categories, as demonstrated by wide clinical use.

Side Effects. Since it may, under some circumstances, produce any of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.

Contraindications. While the only absolute contraindications are tuberculosis and herpes simplex, there are some relative contraindications (peptic ulcer, glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

While no steroid can *cure* a susceptible disorder, many patients who would otherwise be confined in a state of invalidism have, on ARISTOCORT® Triamcinolone, been able to pursue active, useful lives.

References: 1. Levine, R.: Rationale for the Use of Adrenal Steroids, Paper presented at Annual Convention, Medical Society of the State of New York, New York, May 13-17, 1963. 2. Hollander, J. L.: Clinical Use of Dexamethasone. *JAMA 172*:306 (Jan. 23) 1960. 3. Boland, E. W.: Chemically Modified Adrenocortical Steroids. *JAMA 174*:855 (Oct. 15) 1960. 4. McGavack, T. H.: The Newer Synthetic Adrenocortical Steroids in Therapy. *Nebraska Med. J. 44*:377 (Aug.) 1959. 5. Freyberg, R. H.: Berntsen, C. A., Jr., and Hellman, L.: Further Experiences with Δ1, 9 Alpha Fluoro, 16 Alpha Hydroxyhydrocortisone (Triamcinolone) in Treatment of Patients with Rheumatoid Arthritis. *Arthritis Rheum. 1*:215 (June) 1958. 6. Cahn, M. M. and Levy, E. J.: Triamcinolone in the Treatment of Dermatoses. *Amer. Practit. 10*:993 (June) 1959. 7. AMA Council on Drugs: New and Nonofficial Drugs. *JAMA 169*:255 (Jan. 17) 1959. 8. McGavack, T. H.; Kao, K.-Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: Clinical Experiences with Triamcinolone in Elderly Men. *Amer. J. Med. Sci. 236*:720 (Dec.) 1958. 9. Fernandez-Herlihy, L.: III. Use and Abuse of Corticosteroid Therapy—The Structure and Biologic Activity of the Corticosteroid Hormones and ACTH, *Med. Clin. N. Amer. 44*:509 (Mar.) 1960. 10. McGavack, T. H.: Triamcinolone: A Potent Anti-inflammatory Sodium Excreting Adrenosteroid. *Clin. Med. 6*:997 (June) 1959.

maximum steroid benefit—minimum steroid penalty

Aristocort®
Triamcinolone
1 mg., 2 mg. or 4 mg. tablets

Lederle LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
229-3



THE INSURANCE PAGE



The Goose That Laid The Golden Eggs

BLUE Shield has been criticized at times on the ground that it tends to cause standardization of physicians' fees.

To a certain extent, this is true—just as it is true that other types of health insurance also tend to influence the fees for the services which they cover. Most people today, including the wealthy, have some form of protection against the cost of illness; and as a result, the public has become fairly sophisticated concerning medical costs.

As a matter of fact, many medical and surgical specialty organizations have developed for their members lists of suggested minimum charges for various procedures. These lists, too, have helped to form an "average fee" concept on the part of the physicians, so that such fees are more uniform than they once were.

While is is true that physicians' fees as a whole in some areas of the nation are definitely higher than they are in certain other areas, public opinion and public reaction to fees also places certain limitations on the amounts which physicians charge. Many medical societies have formed special committees of their members to which insurance companies or individual patients may present their grievances, when it is felt that a physician's fee has been unjustifiably high.

The concept of charging as much as the traffic will bear is seldom done today. It is a little difficult for a patient to understand why he must pay twice as much for a certain service as the same physician charged his neighbor, who happens to be slightly less affluent.

This is not to say that Blue Shield pays the same amount for each medical service under all circumstances. On the contrary, there are available today the Blue Shield subscribers many levels of payment. The standard contract, which was intended primarily to protect people of relatively low income, and which has correspondingly low premium charges, pays amounts which are usually below the average fees charged by physicians. More realistic schedules of indemnities are offered by thepreferred plans, and by the newer schedules which have been developed recently.

It cannot be denied, however, that familiarity with these and with other prepayment schedules of indemnities causes many subscribers to question the correctness of unusually high fees.

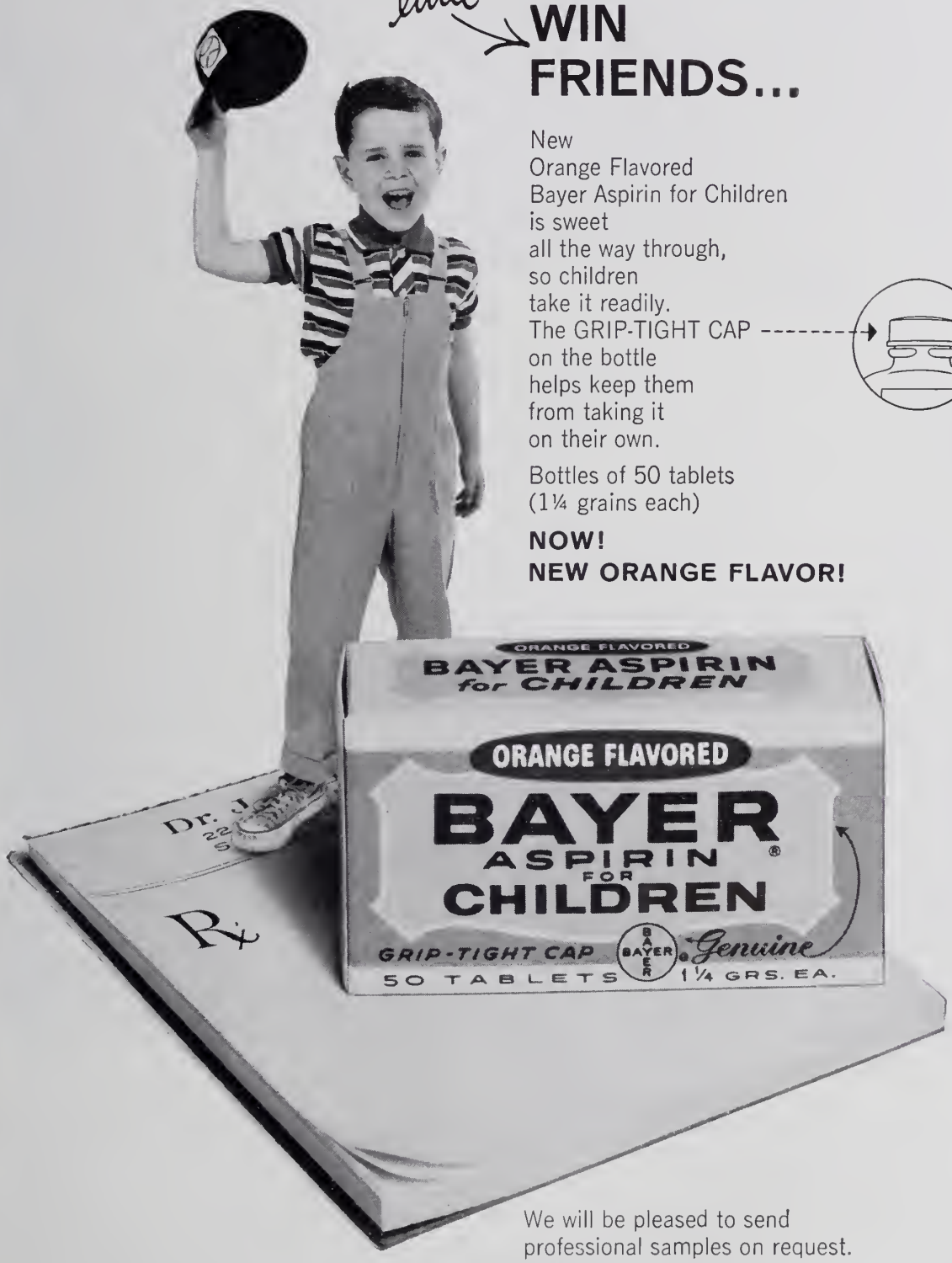
There is another side of the picture. The development of Blue Shield and of other prepayment plans has made it possible for most people today, even those of limited income, to provide prompt payment for their medical fees. Because of this, physicians' incomes are in most instances higher than they have ever been in the past.

It would be foolish to kill the goose that laid the golden eggs, simply because the size of the eggs did not vary enough to suit everyone.

W. Vinson Pierce, M.D.

HOW TO WIN FRIENDS...

little



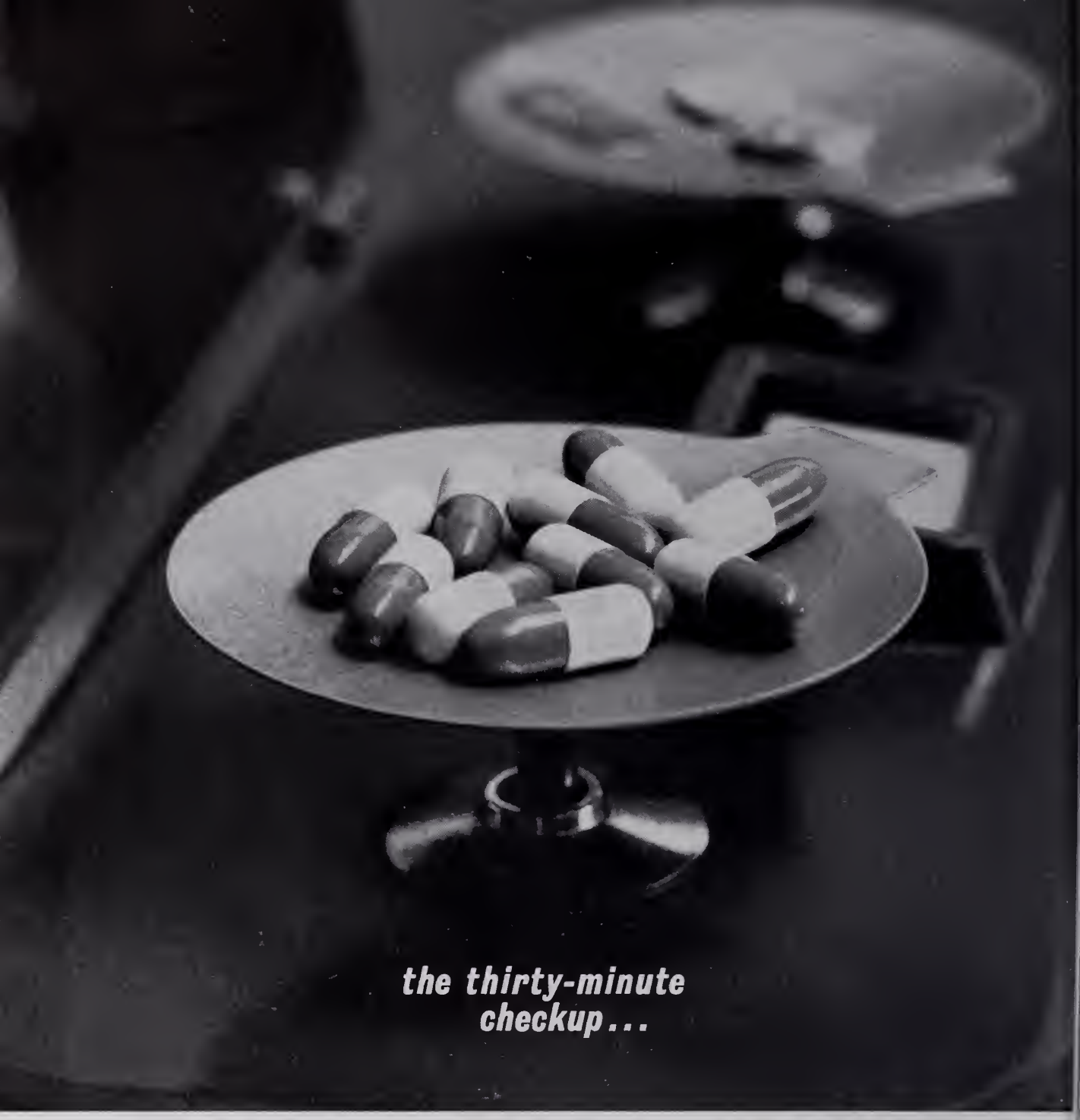
New
Orange Flavored
Bayer Aspirin for Children
is sweet
all the way through,
so children
take it readily.
The GRIP-TIGHT CAP
on the bottle
helps keep them
from taking it
on their own.

Bottles of 50 tablets
(1¼ grains each)

NOW!
NEW ORANGE FLAVOR!

We will be pleased to send
professional samples on request.

THE BAYER COMPANY
Division of Sterling Drug Inc. Dept. 112
1450 Broadway, New York 18, N.Y.



Empty capsules are filled by the finest precision machinery available . . . but no machine is perfect. That's why all Lilly Pulvules® (filled capsules) are given the "thirty-minute checkup" to be certain that uniformity is maintained. At least once every thirty minutes ten filled capsules are taken from each machine and carefully weighed on a prescription balance. In addition, the checks are double-checked at least four times each day . . . another of the many stringent controls which assure you that the Lilly products you prescribe provide quality that merits the full measure of your confidence.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

300680

The JOURNAL of the
Kentucky State Medical Association

Issued Monthly Under the Direction of the Board of Trustees

VOLUME 62 JANUARY, 1964 No. 1

Disaster Medical Care*

THE EMERGENCY Medical Services Committee of the Kentucky State Medical Association is honored to present some basic information about disaster medical planning and patient care. It is obvious that doctors have an inherent responsibility to care for the sick and injured in disastrous situations regardless of the etiology.



Dr. Rumage

Governmental agencies at all levels have, by law or executive order, assumed the responsibility of making plans to prevent disaster, to maintain life should disaster occur, and to reestablish our usual existance afterwards. All of these plans require tremendous medical man power which, probably fortunately, these governmental agencies don't have at their disposal. Making plans for disaster in no way indicates that you relish or condone war. Such an argument is nonsense. All of our work is directed at maintaining tranquillity and freedom. Nor can we turn our backs on the work involved because of the enormity of the problem or the inevitability of death in large numbers. Our patients are entitled to a more hopeful attitude on our part. Therefore, since you know that you will have to work your hardest and longest in time of disaster, why not participate now in planning so that your efforts on behalf of the sick and injured will be rewarded?

William T. Rumage, Jr., M.D.

* *This special Disaster Medical Care symposium was prepared under the direction of William T. Rumage, Jr., M.D., chairman of the KSMA Committee on Emergency Medical Services. Doctor Rumage is also an assistant clinical professor of surgery at the University of Louisville School of Medicine.*

Governor's Letter of Thanks For Disaster Planning

I VERY much appreciate the opportunity offered by the Kentucky Medical Association to express my thanks to those in Kentucky who have done so much in disaster planning. This issue of the Journal of the Kentucky Medical Association is a wonderful expression of the cooperation that exists between the various governmental agencies and health organizations involved in caring for the people of Kentucky.



Governor Breathitt

I look forward to the development of plans which will attempt to prevent disasterous situations from occuring and making provision for the prompt care of those involved, should disaster strike our Commonwealth.

My very best wishes for continued success.

Governor Edward T. Breathitt

AMA Activity in Disaster Medical Care

MAX L. LICHTER, M.D.*

Melvindale, Mich.

IT IS THE responsibility of the medical profession to be prepared to care for people under any and all circumstances, including the possibility of enemy attack upon this country by weapons of great destructive capability. A sincere desire for peace is not contravened by such preparation. Until we achieve means of controlling the use of modern weapons, the possibility of their deliberate or accidental use should be accepted. It is with this thought in mind that the American Medical Association has gone about the business of urging medical preparedness for disaster.

The activity in this regard has been carried out by the Council on National Security and its Committee on Disaster Medical Care. As a result, the Board of Trustees, the House of Delegates, and the members of the American Medical Association have maintained a keen interest in the problem, and have been kept fully informed of progress.

It is the purpose of the committee to be aware of what is being done by governmental agencies which have been assigned disaster responsibilities by the President. This involves relationship with the Office of Civil Defense, Department of Defense (OCD-DOD), the Office of Emergency Planning (OEP), and the Division of Health Mobilization (DHM) of the U. S. Public Health Service (USPHS).

Since DHM has major responsibility for medical planning, the AMA maintains close relationships with that agency. We are not only aware of what is being done, but we are also involved in the development of policy and projects. As an example, the AMA was consulted in every phase of the development of Medical Self-Help. This was not a casual effort but required many meetings at which the concept and material were critically reviewed. This program grew out of the Family Guide, which was suggested in the AMA Report on National Emergency Medical Care.

The AMA points out to DHM the need for specific planning manuals. Because our committee meets with State Medical Society Disaster Medical Care chairmen through a continuing series of regional meetings, we are able to learn of problems and needs as expressed by these chairmen. These needs then are transmitted to DHM with recommendations for scope and content. As an example, the need for a manual dealing with the Civil Defense Emergency Hospital (CDEH) was widely expressed. DHM now has such material in the final phase of preparation and printing. It will deal with the several major areas of the CDEH and will be made up of five manuals, each dealing with a specific area.

Another example is a concern for a community planning guide. It became obvious that this was needed throughout the country. As a result of AMA encouragement, DHM is now completing an excellent manual which will fulfill the requirements for such a guide.

There are, of course, many more examples that could be cited. The point is the excellent relationship that exists in the field of disaster medical care between the AMA Committee on Disaster Medical Care and the Division of Health Mobilization.

Major Approaches

To bring to state society committees current information and to assist them in dealing with planning and problems, the AMA Council and Committee have developed four major approaches.

(1) There are two national conferences each year to which members of county and state committees are invited. Just before the AMA Annual Meeting, a conference has been held at which outstanding speakers present not only medical information, but also broad civil defense policy. In November a two-day meeting

At the time this article was written, Doctor Lichter was chairman, Committee on Disaster Medical Care of the American Medical Association, and a member of the AMA Council on National Security.

is held which presents specific planning and treatment material, as well as workshops.

(2) Regional meetings are conducted by the Committee so that all OCD-DOD regions are visited in a two-year period. These meetings deal with agency relationships in states and the kinds of problems state committees might have in their planning. Conducted in seminar fashion, opportunity is provided for the exchange of ideas between the several state and county societies. Kentucky is part of OCD-DOD Region #2.

(3) A visitation program has been developed whereby a member of the AMA Committee will consult, upon invitation, with a State Committee.

(4) AMA staff maintains a complete bibliography of all material printed on disaster medical care, together with a complete film catalogue. A Civil Defense Review is printed periodically and is obtainable by a simple request.

Having acted as a catalyst between government agencies and the individual practitioner in the past and in present activities, the AMA will continue in this vein in the future. In the establishment of medical care policies, we will maintain a relationship with governmental agencies consistent with the role of private practice as a responsible party. Fortunately, no political considerations are involved in this relationship.

The association will continue to urge state associations to develop plans within the state, offering every assistance to accomplish this large and important undertaking. Medical schools will be urged to add more disaster medical care material to their curricula, particularly as part of the Medical Education for National Defense (MEND) Program. The allied health professions will be encouraged to develop their capabilities in consonance with the AMA Report on National Emergency Medical Care. In short, the AMA will act in the interests of all professional health people to see that needs are met, information disseminated, and programs are interpreted. In this way the American people can be assured that medicine, having their interests and welfare at heart, as always, is preparing to care for them under any eventuality. It is our purpose not only to encourage and stimulate the committees of state societies, but even more to provide them with information, get answers to questions and let them be aware that other states are working as diligently.

Make no mistake, a great deal is being done by American Medicine in the field of medical care in large scale disaster. Much training has been carried out. Planning and organization at state and local level is continually going on and becoming more efficient. All of this has been done to a great extent by physicians in private practice. The need was evident and the responsibility apparent. No governmental pressure has accomplished this. It has been done and will continue to be done voluntarily.

Plan Now

to attend the

1964 KSMA Interim Meeting April 23

at Jenny Wiley State Park

(See story on page 58)

Medicine, Government, and Disaster Planning

Gabriel P. Ferrazzano, M.D.*
Washington, D.C.

Introduction

THE DEPARTMENT of Health, Education, and Welfare is intimately concerned with the individual, his well-being, his ability to maintain self-sufficiency and to contribute to uniformly high standards of living, as well as to act in concert with all Americans when national circumstances require his participation in wartime productivity or other national services.

National Plan

It was no surprise, therefore, that the President, through Executive Order 11001, and consistent with the *National Plan for Emergency Preparedness,* assigned to the Department, responsibility for developing emergency preparedness measures. Specifically the instructions to the Secretary were that:

> "Emergency plans and programs, and emergency organization required thereby, shall be developed as an integral part of the continuing activities of the Department of Health, Education, and Welfare on the basis that it will have responsibility for carrying out such programs in an emergency."

In contemplation of the need for the various agencies to consolidate their resources in an effort to cope with national disaster, further guidance provided that:

> "The Secretary shall assume the initiative in developing joint plans for the coordination of emergency civilian health services of those departments and agencies which have a responsibility for any segment of such activities. He shall utilize to the maximum those capabilities of other agencies qualified to assist in the performance of assigned functions by contractual and other agreements."

The Secretary promptly announced that, in the event of a national disaster, the Department would have subunits for emergency health and for emergency welfare services. He then delegated primary responsibility for coordinating and developing emergency health plans and programs to the Surgeon General, Public Health Service. Delegations of responsibility were also sent to other Federal agencies having health or health-related responsibilities asking that each cooperate with the Public Health Service in the development of preparedness measures.

Memorandums of Understanding have subsequently been developed with a number of these agencies to interrelate their plans and resources to the *Federal Emergency Health Service*. Other memoranda are in process. The Federal Emergency Health Service is now an actuality, but its programs and activities will not go into effect except in the event of a national emergency.

The Public Health Service's Division of Health Mobilization was assigned primary responsibility in the health preparedness activities. It has had the benefit of the cooperation and advice of the American Medical Association, the American Hospital Association and many other national professional organizations in formulating the plans.

National Goal and Preparedness Area

It was soon evident that the goal was "to prepare a program that will assure the availability of adequate health services for the civilian population in the event of a national emergency." Three programs were identified as essential to achieving this goal.

First, it was necessary to develop the Federal emergency health service to bring together and provide for the emergency coordination of the competencies and resources of those Federal health agencies within the Department of Health, Education, and Welfare, as well as the Veterans Administration, and others having health and health-related interests. Established

Chief, Division of Health Mobilization, U.S. Public Health Services, Department of Health, Education, and Welfare.

were an Office of the Chief, high level general planning staff, and four basic bureaus.

The *General Planning Staff* will advise the Chief concerning the appropriate steps to take during a national disaster and indicate the time for return to peacetime operations.

The *Bureau of Health Operations* will be principally concerned with providing for the delivery of direct health services during an emergency. Its divisions are medical services, community health, environmental health, food and drug programs, and laboratory services.

The *Bureau of Health Manpower* will assist in the obtaining and utilization of health manpower. The bureau functions as a new entity in the manpower field. In previous emergencies, health manpower has been divided between the military and civilian claimants. Steps have already been taken to facilitate the obtaining of both health and supportive manpower by States and local communities. The bureau has divisions for manpower resources and requirements, utilization, and training.

The *Bureau of Health Materiel* will assist the States and communities by acting as their Federal voice to procure the materiel and equipment, and get them manufactured and distributed for emergency use. This requires working relationships with the Business and Defense Services Administration as well as other agencies. This bureau's divisions consist of resources and requirements, claimancy and allocation, procurement, and distribution.

The *Bureau of Water Supply* was established to assure that an adequate supply of safe water will be available for human consumption including hospital use. The primacy of the needs for human use transcends all other uses and makes mandatory the bureau and its divisions for water resources, water facilities, and domestic water.

The regions have developed similar organizations and staffing patterns and the States are also encouraged to give attention to these anticipated needs.

A second major program has been to assist the States and communities in the implementation of their community health plans. Health Mobilization representatives have been assigned to the States to assist with planning and organizing and in sustaining those programs currently underway which are most likely to peacetime accomplishment. The program for the storage and planned use of the Civil Defense Emergency Hospitals—presently consisting of about 1800 prepositioned CDEHs and an equal amount of backup supplies in depots—is tangible evidence of local preparedness. Efforts are now underway to expand the operating capabilities of these hospitals.

The Civil Defense Emergency Hospital Training program is designed to acquaint States and communities with the availability and use of this valuable emergency resource. Physicians, allied health personnel, and other interested citizens have contributed to the progress of this program. The third program is the Medical Self-Help Program which, with the cooperation of State medical societies, health departments, educational leaders, and civil defense officials, has now reached more than a third of a million people. The goal is to reach at least one member of each family so that he may be prepared to help himself, his family and his neighbors during the time after attack when physicians are not available.

In the final analysis we are faced with the possibility of an attack of unprecedented scope. All resources, public and private, will be required for survival and recovery. Those of us in professional ranks, as perhaps few others, have the opportunity to bring our help and resources to where they are most needed—the community and the individual. This is requisite of all echelons of government and, I am sure, you recognize it as a professional moral responsibility as well.

Chemical, Bacteriological and Radiological Warfare

Joseph D. Stokes, M.D.*

Greenville, Ky.

THE physicians should help provide the leadership in solving the problems of defense against chemical, bacteriological and radiological warfare in the development of any civil defense plan.

The devastating effects, the military significance, and the civil defense implications of nuclear weapons have been demonstrated forcibly and all too clearly, both in war and by peacetime testing. Similarly, in World War I, the effectiveness against military forces of what would now be considered rather primitive chemical warfare had such impact that no country has dared to use this weapon since. Biological warfare has never really been field tested under wartime condition, however, many think that it may be the most effective strategic weapon of the three. They all have certain general characteristics in common, producing large numbers of casualties over fairly extensive areas, causing death or interference with physiological processes, and exerting their effects at levels undetectable by the senses, and on brief exposure. They can be used against military installations or urban and industrial complexes. On the basis of these general characteristics alone, to which would have to be added the specific effects of chemical toxins, pathogenic organisms, and ionizing radiation, the sum total of the medical and public health problems would appear almost overwhelming, but for each weapon a defense can be developed.

Radiological Warfare

The effects of thermonuclear* weapons require special consideration. There are four basic differences between thermonuclear and high-explosive weapons: the thermonuclear blast can be many millions of times more powerful; a large proportion is thermal radiation or heat; initial nuclear radiation*; and residual nuclear radiation or fallout*. We will consider primarily the nuclear radiation (see table 1). Both the neutrons and gamma rays produced by the fireball of the explosion travel relatively short distances, therefore this initial nuclear radiation is academic since an individual close enough and sufficiently exposed to be seriously affected would have already succumbed to thermal and blast effects. However, the residual nuclear radiation or fallout is radiation from which we can be sheltered, and which can be detected and measured by good, inexpensive detectors.

In the immediate phenomena associated with a thermonuclear explosion for descriptive purposes there are four types of burst: (1) High altitude (2) air (3) surface, and (4) sub-surface—with the second and third probably being militarily more devastating, especially a surface burst, and the others occurring only when there has been a miscalculation in the firing of the thermonuclear weapon by the offensive nation. A high altitude burst is defined as one in which the explosion takes place at an altitude in excess of 100,000 feet, with the effects negligible except for production of moderate heat, flash blindness or eye burns. An air burst occurs below 100,000 feet with the fireball still not touching the surface of the earth and causes considerable damage from

* *Doctor Stokes is a member of the Kentucky State Medical Association Committee on Emergency Medical Services.*

Table 1

Characteristics of Nuclear Weapon Radiation

Name & Symbol	What Is It?	How Does Bomb Produce It?	What Will Stop It?	Human Hazards Wartime
α alpha	Helium Nucleus	Emitted from unfissioned Uranium and Plutonium. Part of Fallout	Paper, if several mm. thick.	Negligible, not enough gain entrance to body.
β beta	High speed Electron	Emitted by Fission* Products. Also important in fallout	Clothing, if several mm. thick.	Nuisance only, if promptly removed from skin.
γ gamma	Electro-magnetic wave-like visible light	Emitted by Fission Products. Important in both initial and fallout radiation.	Effective shielding with 24" earth, 16" concrete, or 2" lead (fallout reduction 1/1000)	Serious, many casualties initially and from fallout.
n neutron	Electrically neutral body	Emitted only during the instant of fission or fusion*	Several feet of concrete or earth	Serious, initial radiation only

heat, initial nuclear radiation and blast effect, but negligible fallout. In a surface blast which occurs either at or slightly above the actual surface of land or water, the effects of heat, initial nuclear radiation and blast will be severe but less extenive than for an air burst. However, early fallout will be a serious hazard, especially over a large area downwind from the burst (see table 2). In a sub-surface burst that does not penetrate the surface, the only hazard will be from ground or water shock.

As previously stated, fallout will be the factor concerning the largest segment of population, as the entire nation would be subject to the likelihood of fallout radiation, whereas only the areas in the vicinity of the thermonuclear explosition will be subject to the hazards of blast, fire and initial nuclear radiation. Fallout alone could produce 90% casualties. After a thermonuclear explosion, when the fallout arrives, the dose rate increases steadily until the fallout is complete in a few hours, then begins a steady decrease in dose rate due to radioactive decay*. Decay will be tenfold to every sevenfold elapse of time. Thus a rate of 1,000r*/hr at the height of fallout will be reduced to 100 r/hr seven hours later, and to 10 r/hr at two days (forty-nine hours), and 1 r/hr at two weeks.

The Federal Government will provide warning against an attack. The National Warning System carries the warning signal from the Headquarters of North American Air Defense Command to State warning points, instantaneously to the Governor, and down through the State Police. During this last year the office of Civil Defense has been studying national installation of a new warning system, the NEAR System, which would bring the warning into every home with electric power. The NEAR System operates through signal generators placed in the electric grid, with these generators activated directly by the National Warning System, and in turn, activating buzzers plugged or wired into home electrical circuits. Information during any enemy attack will be disseminated by the Emergency Broadcast System which replaced CONELRAD in early August, 1963. It will open the entire A. M. broadcast band, instead of only 640 and 1240, to broadcasters authorized to stay on the air.

Acute Radiation Injury

Even if the dose individually received is not known, clinical diagnosis and triage on the

* See definitions on page 30

Table 2
Nuclear Bomb Effects—Surface Blast

Damage and Injuries (No Shelter)	1 Megaton*	10 Megaton
Crater	650′ radius 140′ deep	1,250′ radius 240′ deep
Initial nuclear radiation, death from 700r	1.5 miles radius 7 sq. mile area	2 miles radius 12.5 sq. mile area
Blast—collapse of brick building, injury from flying debris	3 miles radius 28 sq. mile area	7 miles radius 150 sq. mile area
Thermal radiation—fires set to curtains and light kindling, second degree burns on bare skin	9 miles radius 250 sq. mile area	25 miles radius 2,000 sq. mile area
Fallout—400r in 48 hours with 15 knot wind	40 miles downwind (wind usually from west to east) 5 miles crosswind 200 sq. miles	150 miles downwind 25 miles crosswind 2,500 sq. miles

basis of signs and symptoms is possible. Of the radiation dose received, 10% of the injury is irreparable, with repair of the remaining 90% at the rate of 2.5% per day. The acute lethal whole body dose is about 650 r, however, an individual may receive double that dose and survive if the dose is divided over a two week period.

Immediately after an attack, the common prodromal symptoms of the acute radiation syndrome of malaise, anorexia, nausea, vomiting and diarrhea will be thoroughly confounded with the symptoms of psychic upset and other injuries, therefore, the patient may have to be observed for several days or weeks. After the prodromal stage there will be a latent period for one to three weeks depending on the severity of the radiation injury. In the most severe form this period is absent. Those who have received lethal doses will probably develop significant symptoms in the first 24 hours.

The Syndrome is best divided into five groups as follows:

Group I (50-200r dose)—Less than 50% vomit within 24 hours; weakness, fatigue, moderate leukopenia; with less than 5% needing medical care.

Group II (200-450r dose)—Over 50% vomit; sick for a few days, then latent period of 1-3 weeks. Manifest illness begins about the 20th day with severe leukopenia, purpura, infections and epilation. Over 50% survive, but survivors noneffective for several months.

Group III (450-600r dose)—All will vomit, with more severe symptoms and shorter latent period than Group II, characterized by severe hemorrhage and attendant infections. Less than 50% survive, and survivors noneffective for over six months.

Group IV (600-2,000r dose)—Immediate protracted vomiting and intractable bloody diarrhea persisting until death in approximately 7-10 days, due to destruction of the gastroenteric mucosa.

Group V (several thousand r dose)—Large doses result in very rapid injury to the central nervous system with immediate disorientation, ataxia, confusion and difficulty in breathing. There is watery diarrhea and cardiovascular collapse with survival only for a few hours or perhaps a few days.

Treatment

In considering treatment there will be a great disproportion between medical needs and medical means. During the period of dangerous radioactive contamination a very large number of casualties will receive no more than self- or first-aid care, with no definitive medical care provided until after a "pindown" period of a few days to as much as two weeks. Instead of heroics during the time of intense radioactivity we should conserve our energies and medical resources to cope with the staggering definitive treatment job that will face us after the fallout shelter period. We should not abandon traditional medical responsibilities, however, we should utilize the available treatment potentialities for those who require the least treatment and can perform the most work, and thus bring about the eventual rebuilding of our economy.

Most people within a ten mile radius from detonation of a bomb of megaton* power will be killed by blast and heat, unless they are fortunate enough to be in a fire and blast resistant structure. In the ten to twenty mile radius and beyond, it may be possible to remove patients with traumatic injuries and thermal burns to shelter areas for treatment, provided sufficient time is available before arrival of fallout, which may be only 20 to 30 minutes. Treatment of injuries and burns will follow normal methods of practice, except for burns produced by beta particles (dose of over 1,000 r); these patients should first be thoroughly decontaminated by a soap or detergent as quickly as possible, followed by conventional burn therapy.

The major treatable changes of the acute radiation syndrome are infection, leukopenia and anemia, and hemorrhage. Ideal medical care for an individual patient of Group II or higher would be hospitalization in a sterile environment with good nutrition, antibiotics, and blood, platelet or even marrow transfusions. However, in mass catastrophies no such therapy will be available. Thereapy for radiation should be reserved for Group II patients since they have the greatest potential for rehabilitation. Also, Group I patients should be provided with good food and rest if possible since they will be able to work. Prophylactic antibiotics and blood should not be given. Antibiotics should be given only for definite evidence of infections. If patients with combined injuries (trauma or thermal plus radiation) are in Group III or above, therapeutic efforts should be only palliative if medical resources are limited.

The most important single plan of the treatment of radiation sickness is nursing care with maintenance of scrupulous cleanliness, adequate fluid intake, high calorie, vitamin and protein diet, and rest. This nursing care and symptomatic treatment with sedatives, analgesics, antidiarrheal and antiemetic drugs plus antibiotics will probably be the maximum medical therapy available for radiation injuries.

Recovery and Long Term Survival

In the recovery after the sheltering period, decontamination would begin by removing fallout particles from houses, streets and other areas by washing off the fallout, and from exposed areas by scraping off a thin top layer of soil. Food and water will be less of a problem then most people think, as radiation going through food or water does not cause any effect, the only danger would be from fallout which got inside the food. Containers of food would need to be washed off, and exposed food would need only to be washed off or the outer layer discarded. As the fallout particles are large in water they would settle out, and by distillation all the fallout particles would be removed. Boiling has no effect on the particles.

In considering long-term survival there has been a great deal of speculation, however, there are some estimates that we should use as a guide in planning. From fires, floods and erosion, there would be an enormous loss of arable land, with the floods involving primarily the soil rich plain areas. A major attack would probably destroy tens of thousands of square miles of arable land; however, this country has more than three million square miles of land.

Following a thermonuclear war most of our livestock would be killed, as there would be no economical way to shelter them. We can easily exist largely on grain for several years until the herds are replenished. Also, there would be major changes in the plant life, and sufficient food to maintain the population could not be grown for two or even three years after an extremely heavy attack. Therefore, we would exist on grain. A two year supply is available now.

Insects are more resistant to radiation than mammals and birds and they might multiply wildly, though a balance might be maintained by the predatory insects and spiders, since they are also resistant to radiation.

Following a thermonuclear war there would be an increase in congenital malformations by about 1% of the total birth rate, which would be significant but a minor problem in relation to the other risks of a thermonuclear attack. The greatest hazard by far in terms of survival is the increase in leukemia and bone cancer, which could be expected in young children following radiation. In two weeks' time most of the radiation has disappeared, but long-acting atoms remain, particularly strontium-90 and cesium-137. Growing bones would take up this strontium-90 instead of calcium, and on the basis of a 7,000 megaton attack, roughly 50% of the children in every family would die of leukemia or bone cancer, for several generations. Protective measures can reduce this risk, the simplest method being the feeding of calcium tablets to children daily after an attack, reducing the incidence of leukemia and cancer by about five times. Other measures also could help, such as storing dried milk, adding calcium to the soil before an attack, or using ion exchange devices to remove the strontium-90 from milk, and removing a thin layer of top soil.

Table 3
Agents of Chemicol Worfore

Group	Exomples	Deodliness	Specific Antidote If Any	Other
Tear Gases	Ethyl bromoocetate Chloroocetone Chloroacetophenone Benzyl Bromide	Practically none		
Choking Goses	Chlorine Methyl sulfuryl chloride Phosgene Diphosgene Chloropicrin	Moderate	None	
Blood Poisons	Hydrogen Cyonide Cyonogen Bromide Cyonogen Chloride	High		Rapidly dispersed and diluted by wind.
Blister Goses	Mustord Gos Lewisite (other orsines)	Moderote	BAL.	Effective ogainst skin; standard gas masks don't give adequate protection. Persists for long period.
Nerve Gases	Tabun Sarin (G.B.) Aryl Corbamote	High	Atropine Prolidoxime	Absorbed through skin; standard gas mask inadequate. No warning odor—Anticholinesterase oction.
Incopocitoting Agents	Mescoline LSD 25 Psilocin	Minor	None	

Chemical Warfare

As paradoxically the very power of the nuclear weapon has, in many ways, limited its usefulness, our attention has focused more on chemical and biological operations. These two methods of warfare are frequently linked in discussion of possible future wars, as there are many similarities, previously mentioned. However, there are two important differences, as chemical agents act rapidly within minutes to hours instead of days, and as they do not renew themselves, they must be transported from the attacker in enormous quantities to be militarily effective. Another important factor in the use of chemical agents, as with biological agents, is that they are antipersonnel only and do not destroy cities and industries, and they are extremely cheap to use. Even though some of the chemical agents are poisonous in minute quantities, when spread over a large area they become ineffective, and the most poisonous are those which are most readily dispersed and diluted by winds.

The most toxic compounds in this group are the nerve gases which can be disseminated over large areas as an odorless, tasteless and invisible cloud. Their anticholinesterase activity produces the following signs and symptoms: extreme miosis (early) and impaired accommodation; profuse salivary and bronchial secretions; nausea, vomiting, diarrhea, and urinary difficulties; generalized muscular weakness and paralysis, especially of respiratory muscles; convulsions, coma and death usually within ten minutes. Without detection devices the first knowledge of an attack would be the development of the above symptoms. A ten-ton load of such a nerve gas would kill unprotected persons within an area of one square mile which might mean millions of casualties if the missile hit a crowded city. However, in comparison, a similar load of hydrogen bombs could kill over an area of 10,000 square miles.

Other poison gases which are currently known (Table 3) are less toxic then the nerve gases, and there appears to be little likelihood of their extensive use in a subsequent major war. The well-known mustard gas can produce severe burns of the skin and pulmonary necrosis and edema; however, it is neither fast-acting nor highly lethal. Even the well-publicized hallucinogenic agents which can disrupt patterns of reasoning and behavior have a relatively low range of effectiveness in comparison to the same weight of a thermonuclear bomb. However, one can never rule out the possibility that poison gases will be used, as they could produce considerable panic and hysteria.

Defensive Measures and Treatment

The defensive measures to be taken against chemical warfare are detection, warning and protection. Some can be detected by the senses, as mustard gas has a garlic-like odor, but others such as the nerve gases act so rapidly that automatic detection equipment would be necessary.

There are three basic features of protection against chemical agents. First, the diluting effect of winds is automatic. The second method of protection is the use of masks with charcoal filters and protective rubberized clothing. The third method of protection is a sealed shelter with an oxygen supply (the same basic protection as for nuclear firestorms).

In comparison with biological and nuclear weapons, chemical weapons will probably cause the smallest total medical loss but highest proportionate loss of life, due to their rapid action. For the nerve gases, immediate triple therapy is indicated, consisting of multiple 2 milligram injections of atropine, mouth-to-mouth artificial respiration and an oxine to relieve the respiratory muscle paralysis. Mustard or nerve gas on the skin must be removed by washing with soap and water, and by removing contaminated clothing. In the absence of an antidote, all that can be done is to furnish shelter and protection from self-harm. As shown in Table 3, specific antidotes are needed for several of the chemical agents.

Biological Warfare

Even though biological weapons have not been employed as a major weapon, there is sufficient evidence they would be effective. A careful analysis indicates that adequate defense is possible. Biological weapons are antipersonnel only and require days to weeks to produce casualties. Biological warfare agents are primarily infectious microorganisms but toxins could also be used in a manner similar to chemical agents.

Biological agents must possess certain properties in order to be useful for military purposes. They must be highly infectious, readily producible in large quantity, and stable. Aerosolization is important as an aerosol is the logical method for large area coverage. There should be minimal immunity to the particular agent in the target population. The diseases that must be considered as definite threats are: tularemia, Q fever, typhus, psittacosis, dengue, yellow fever, anthrax, arthropod borne encephalitides and coccidioidomycosis. It is unlikely that biological agents would be used in an initial surprise attack due to the incubation period of several days during which time the defensive nation could retaliate with thermonuclear weapons. It would be more logical to use the biological agents with the thermonuclear weapons.

The use of bacteriological agents against our crops and animals appears unlikely because the diversity and vigor of our agriculture, with our grain stockpiles, is so much greater than that of any potential enemy country.

Table 4
Vaccine Status—1962

In Standard Use	In Development Phase	Under Study
Smallpox[1]	Typhus (Strain E1[1]	Russian Spring Summer Encephalitis[1]
Yellow Fever[1]	Tularemia[1]	Brucellosis[1]
Tetanus	Q Fever	Tuberculosis
Diphtheria	Rift Valley Fever	Staphylococcal infection
Poliomyelitis[1]	Venezuelan Equine Encephalomyelitis[1]	
Rabies	Eastern Equine Encephalomyelitis	Trachoma
Pertussis	Western Equine Encephalomyelitis	Ornithosis
Typhus	Measles[1]	Shigellosis
Typhoid	Anthrax	
Adenovirus	Leptospirosis	
Cholera	Botulinum	
Plague		
Influenza		
Rocky Mountain Spotted Fever		
Mumps		

[1] Attenuated living vaccine.

Defensive Measures and Treatment

The most potent agency for destroying infectious microorganisms is ordinary sunlight, and the highly infectious organisms are the most easily destroyed. Therefore, the danger from them comes in the early minutes or hours after they have been spread, in addition to contact with infected individuals. There are many ways the risk of infection can be reduced, the most effective being active immunization. Vac-

cines have been developed from microorganisms, and others are in the developmental stage (see table 4). Research is necessary to determine which to develop, stockpile, and use for mass immunization, and whether to speed up immunization by using combined antigens, aerosol vaccines, or jet injection guns. Another protective measure is the scrupulous maintenance of hygienic conditions, and the avoiding of congregations and crowds. For effective medical defense rapid identification of the etiological agent is essential. The fluorescent antibody technique which requires only a matter of minutes may answer this need. Fallout shelters with appropriate filters, and protective masks would protect directly against the infectious agents.

The prophylactic use of antibiotics would require 4,000 tons to treat the entire United States population, whereas our annual production is only a few hundred tons. As antibiotics are effective in most bacterial and rickettsial diseases considered of importance in biological operations, they should be reserved for the time when these infections occur. If the enemy used a viral agent the only treatment that we could offer would be supportive. If our planning has been correct, it is reasonably certain that medical care in case of a biological weapons attack will be sufficient.

Summary

When facilities are strained to the extreme, when destruction is maximal and confusion at its height, the duty of the physicians should be directed to those whose chance for survival is greatest so that the survivors can help to care for the less fortunate and aid in rehabilitation of the disrupted society.

In planning against these hazards the amount of protection that will be available is directly related to the extent of public knowledge, developed protection measures, and the steps taken prior to the attack to put these measures into a state of readiness. There are certain actions which can be taken by the unprepared in extreme emergencies to minimize the hazards during and following an attack, however, the protection achieved is minor when compared to that which would be available to those who had made adequate preparations. Many questions are still to be answered but there is every reason to believe that with intelligence, courage, and preparation answers can be found to the problems of the future as answers have been found to the problems of the past.

Definitions

Fireball—The large, swiftly expanding sphere of hot gases, producing brilliant light and intense heat, that is the first manifestation of a nuclear explosion. After about a minute, the fireball fades into the atmosphere.

Fission—The process whereby the nucleus of a heavy atom (as uranium) is split into two nuclei of lighter elements, with the release of substantial amounts of energy.

Fusion—The process whereby the nuclei of light elements (as hydrogen) combine to form the nucleus of a heavier element, with the release of substantial amounts of energy.

Initial Nuclear Radiation—The nuclear radiation (essentially neutrons and gamma rays) emitted from the fireball and the cloud column during the first minute after a nuclear explosion.

Megaton—A one-megaton bomb is equal in power to one million tons of TNT, 50 times more powerful than the A-bomb dropped on Japan.

Nuclear Weapon—Customarily refers to weapons in which all the energy results from fission, as atomic bombs.

Rad—Can be used interchangeably with roentgen, a unit of absorbed dose of radiation.

Radioactive Decay—The decrease in activity of any radioactive material with the passage of time, due to the spontaneous emission of alpha, beta and gamma rays.

Residual Nuclear Radiation (or *Fallout*)—Nuclear radiation, chiefly beta particles and gamma rays, which persists for some time following a nuclear explosion.

Early fallout is that which reaches the earth within the first 24 hours, and the *delayed fallout* is the smaller particles that ascend into the troposphere and stratosphere, falling over the entire earth months and years later.

Roentgen (*r*)—The unit of exposure dose of gamma (or X-) radiation.

Thermonuclear Weapon—A weapon in which part of the explosion energy results from fusion, in addition to fission; as hydrogen bomb.

Bibliography

1. Benenson, Col. Abraham S.: Immunological Countermeasures, Military Medicine, February, 1963.

2. Crozier, Col. Dan: Medical Defense Against Biological Weapons. 13th County Conference on Disaster Medical Care, November 4, 1962.

3. Department of Defense: Fallout Protection—What to Know and Do About Nuclear Attack, December, 1961.

4. Donaldson, Alan W.: Pinpointing the Physician's Responsibility in Chemical Biological and Radiological Defense. 10th Annual National Conference on Disaster Medical Care, June 23, 1962.

5. Fothergill, Leroy D.: Biological Agents—The Threat. 11th Annual National Conference on Disaster Medical Care, June 15, 1963.

6. Garb, Soloman: Thermonuclear Survival. Missouri Medicine, February, May, 1963.

7. Glasstone, Samuel Editor: The Effects of Nuclear Weapons, April, 1962.

8. Hackett, Lt. Col. Louis J.: Medical Aspects of Civil Defense. 11th Annual National Conference on Disaster Medical Care. June 15, 1963.

9. Hartford, Maj. Gen. Thomas J.: Medical Defense Against Biological Weapons. Military Medicine. February, 1963.

10. King, Capt. E. Richard: Survival in Nuclear Warfare. Ciba Symposia. Winter 1962.

11. Libby, Willard F.: You Can Survive Atomic Attack. Associated Press, 1961.

12. Soenger, Eugene L., and Boone, Max L. M.; Radiation Casualties—Newer Aspects of Mass Casualty Care; 13th County Conference on Disaster Medical Care, November 4, 1962.

13. Watrous, R. M. Editor: Management of Mass Casualties. What's New. April-May, 1961.

Civil Defense Disaster Plans For Kentucky

Col. Leon J. Reed*
Frankfort, Ky.

THE world situation has become such that people are growing extremely conscious of the problem of survival in the event of a nuclear war. Knowledge of what to do in such an eventuality will make the difference in whether or not we, as a nation and as individuals, and our way of life can survive. Therefore, it is important that each member of our society fulfill his or her obligation in this task.

Potential enemies of the United States have the capability of launching an attack with sufficient nuclear weapons to strike a high proportion of our military, industrial, and population targets. These may be delivered by missiles, by submarines, and manned aircraft. While the blast effect of these weapons will be tremendous, an additional and more extensive hazard will result in the form of radiological fallout. Such an attack on the United States and the major industrial cities of Kentucky may disrupt the governmental and economic systems of the State. Emergency measures will be required to provide medical care, food, lodging, and other services to large numbers of injured or displaced persons.

The State of Kentucky, organized for emergency non-military defense, has the capability of surviving an enemy attack. An essential part of preparation is the mustering of Kentucky's resources of materials and manpower. Manpower and material resources can be fitted into an M-Day plan that will insure their complete and efficient utilization.

Possible Target Cities

The Office of Civil Defense, Department of Defense, has designated as possible targets in Kentucky, the cities of Ashland, Louisville, Hopkinsville, and Paducah. There are two areas, in other states, which if attacked would affect Kentucky, i.e., Evansville, Indiana, and Cincinnati, Ohio. Any attack on these cities would seriously affect Henderson, Covington, and Newport.

Current Federal policy does not advocate wholesale evacuation of our centers of population, but advocates the utilization of home or nearby shelters, affording protection from fallout. In some areas of the State, this involves the movement of individuals from areas where there are no shelters, to nearby areas where suitable shelters are available.

To meet the needs of our population, it becomes necessary for each city and county to develop a medical plan for disaster. A Medical Civil Defense Program must take several factors into account. First, it must be prepared to treat casualties from nuclear attack. Second, it must be prepared to insure a continued sanitary environment, particularly under the circumstances of evacuation for both casualties and non-casualties. Third, it must be prepared for biological and chemical warfare and the different kinds of casualties that would result from their use.

The Kentucky Division of Civil Defense has in the basement of the New Capitol in Frankfort, Kentucky, a working Emergency Operating Center, in which the Kentucky State Departments of Health, Agriculture, Highways, and Public Safety (State Police) play an important role. It is at this Emergency Operating Center that all aid for any disaster area is coordinated. Here direct communications are available, both down to the counties, as well as up to the National level.

Each county is encouraged to establish, preferably at the county seat, an Emergency Operating Center through which, in time of disaster, all disaster plans for the county will be coordinated.

Outside of the immediate blast area, our biggest concern will be the treatment of individuals who have been exposed to radiation. To aid in this program, the Kentucky Division of Civil Defense has instituted an extensive program in the training of radiological monitoring in-

continued on page 75

Civil Defense Plans and Operations Officer, Department of Military Affairs, Frankfort.

Evacuation and/or Shelters——— When and Where in Kentucky

Lt. Col. Louis J. Hackett, Jr., M.C., U.S.A.*
Washington, D.C.

The New Civil Defense Approach

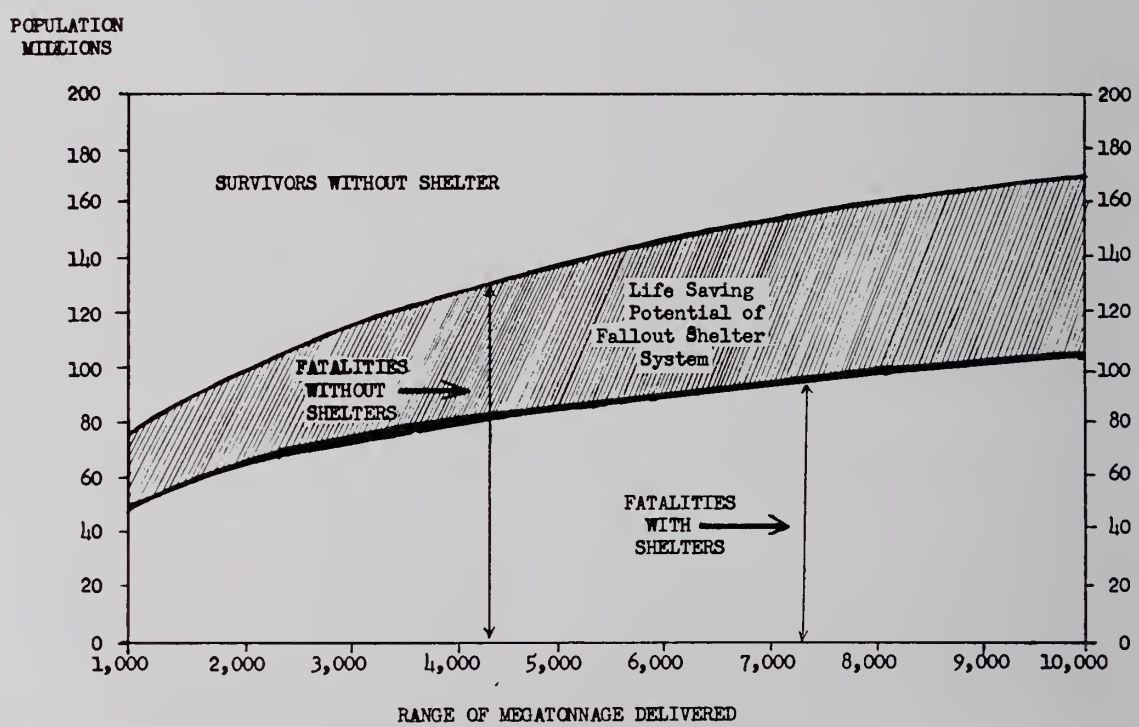
THERE is a new approach to civil defense. Since the Department of Defense took over responsibility in August 1961, studies of many possible attack patterns, with variations in sizes of weapons and arrays of targets, have consistently showed that after any large-scale nuclear attack very large areas of the country will be covered with radioactive fallout of such intensity as to be dangerous to life. The entire country is subject to this hazard. There is no place to run. The only recourse is to have physical shielding. *Thus fallout shelter is the core of civil defense,* and a basic concept is to provide a protected place for everyone in every community. A balanced, fallout-oriented civil defense program could save scores of millions of lives in the event of attack. (Figure 1).

*Medical Advisor, Office of Civil Defense, Department of Defense, Washington, D.C.

Evacuation Outmoded

Modern weapons have greatly increased yield and speed of delivery. The realization that even nontarget areas may be covered with dangerous fallout, and the possibility of attack with very little warning, make infeasible most plans to evacuate large groups of people from potential target areas. The evacuation of our cities could not be expected to save a measurable number of lives under nuclear attack. However, experience gained in evacuation planning and in the coordination of the many

Figure 1.



In event of attack against military targets alone, total fatalities would be reduced and life saving potential of shelters would be increased.

Status Shelter Survey, Marking and Stocking in Kentucky

(As of Nov. 25, 1963)

Number of shelter facilities providing a protection factor of 40 or greater identified in the National Shelter Survey	1,556
Number of potential shelter spaces in these facilities (one space = one individual)	1,865,000
Number of facilities marked with shelter signs	1,091
Number of shelter spaces in marked facilities	1,243,000
Number of shelter spaces stocked with essential survival supplies*	373,000

*Essential survival Supplies furnished by the Federal Government include:

a. Food—10,000 calories per rated shelter space
b. Water Containers—3½ gallons per rated shelter space
c. Sanitation Kits—quantity sufficient
d. Medical Kits—austere, for on-going medical needs of sheltered population
e. Radiological measuring instruments

Figure 2

supporting police, transportation, communications and other services can be applied with slight modification to present civil defense needs. An orderly procedure must be established for movement of people to shelter; and for the post-attack period, movement control planning is required for the relocation of people to areas of lesser radioactivity or destruction. Natural disasters such as floods and storms may require evacuation of many people from areas of danger.

Statistical Background

Statistics are seldom exciting, but certain statistical data may help the planner inventory his resources and measure the magnitude of his problem.

The Commonwealth of Kentucky had a 1960 population of 3,038,156 persons, with a wide spread of population densities. Only one of the 120 counties (Jefferson, with 610,947) had a population of more than half a million. Two counties, Fayette and Kenton, had populations in excess of 100,000 and eight additional counties more than 50,000. Thirty-three counties had populations less than 10,000 people, and three counties were smaller than 5,000 people.

For the Commonwealth as a whole the status of shelter survey, marking and stocking as of 25 November 1963, is shown in Figure 2.

Much potential shelter space exists today, but it must be marked and stocked to be usable, and we must make up the deficit of nearly one and a quarter million spaces which have to be found to provide shelter for all Kentucky citizens. Many of the needed spaces will be found in private home shelters, especially in the rural, sparsely populated areas. Others will become available as new offices, hospitals, governmental and industrial buildings are built or modified to provide fallout protection.

Both natural and war-time disasters are likely to extend beyond the confines of political boundaries. This suggests that consideration should be given to area planning if we are to use most efficiently the available manpower and material resources in meeting such disasters. Thus it is logical to think of certain concentrations of people and industry as single areas, disregarding political boundaries. The Bureau of Census terms these "Standard Metropolitan Statistical Areas." Kentucky shares four such areas with neighboring states, and fully contains one. Information concerning these areas (Figure 3) may be of some interest for planning purposes.

continued on page 81

Figure 3

Standard Metropolitan Statistical Areas	Total 1960 Resident Population	1960 Population (Ky. Part)	Shelter Spaces Located PF 40 & Above	Shelter Spaces Stocked (As of 25 Nov. '63)	% of Population
Cincinnati—Ohio-Kentucky	1,072,000	207,500	488,000	132,627	12.4
Evansville—Indiana-Kentucky	199,000	33,500	128,000	0	0
Huntington-Ashland—W. Virginia-Kentucky-Ohio	255,000	52,100	89,000	11,095	4.4
Lexington—Kentucky	132,000	132,000	87,439	26,666	20.2
Louisville—Kentucky-Indiana	725,000	610,900	484,719	138,293	19.1

Emergency Health Services in Kentucky

Russell E. Teague, M.D.*
Frankfort, Ky.

THE PEOPLE of our state and country are constantly faced with the problem of natural disasters, such as the floods which frequently strike areas of Kentucky. Each year, as our population increases and becomes more urbanized, larger numbers are exposed to potential or actual disasters, particularly in industrialized population centers. In thermonuclear war we face the ultimate threat which could be directed simultaneously to many cities causing widespread destruction and extensive fallout.

Most localities would, for a number of weeks, have to function without outside support and would have to utilize to the greatest extent possible their own remaining medical resources for survival and recovery.

In a typical thermonuclear attack, it is estimated that the casualty level nationally could reach 60 million persons. The approximately 10 million immediate deaths could increase to 34 million within 30 days and more than 40 million at the end of six months.

Health Mobilization Program

A prominent role in the health preparedness program within the Kentucky State Health Department is taken by the Health Mobilization Program which coordinates all medical aspects of civil defense under the direction of the Health Commissioner.

The foregoing responsibilities were delegated to the Kentucky State Health Department by an Executive Order issued by the Governor on April 27, 1960, which states, "The Department of Health shall be responsible for emergency health services; for emergency control of medical supplies; and for the coordination of radiological, chemical, biological, and defense operations." In keeping with this assignment, the Commissioner of Health at that time appointed a Director of Health Mobilization to coordinate the health program for Kentucky.

Emergency health services depend on the development of a plan for the organized use of physicians and allied health professions, medical and surgical supplies, and hospital facilities. With the Kentucky State Medical Association and the Division of Civil Defense, the State Department of Health has set forth as a goal the preparation of a program that will assure the availability of adequate health services for the civilian population in the event of a national emergency.

Emergency health preparations are a major concern of the State Health Department in coordinating emergency plans with the State Medical Association, local medical societies, and the American Red Cross. These include the preparation of allied medical groups in their additional functions during a national emergency. In emergency health preparation we have services to support the primary mission which is the preservation of life, care for the injured and ill, improvement of environmental and community health, control of the spread of communicable diseases, and the many other serious medical and public health problems that would face the State Health Department during a national disaster.

Education of the public through local medical societies, public health agencies, Red Cross, and civil defense agencies is essential. As we must assume that operations will be completely decentralized in the immediate post-attack period, preparedness begins with the individual's ability to survive, the community's ability to reconstruct its health organization, and so on up the line to the emergency national capital.

One major program of the State Health Department is making assignments and inspections of Civil Defense Emergency Hospitals (CDEH's) in local communities. These hospitals are being prepositioned under the direction of the U. S. Public Health Service and the State Health Department. Each CDEH involved in this program has a 30-day supply operational capability. Kentucky has 26 CDEH's, one being a training unit.

* *Commissioner of Health, Commonwealth of Kentucky*

In preparing the civilian population to meet their own health needs when deprived of the services of a physician, the Medical Self-Help Training Program has been developed as a cooperative effort of the U. S. Public Health Service, American Medical Association, and the Office of Civil Defense, Department of Civil Defense. It is being administered by the Health Mobilization Program under the direction of the Health Commissioner. Its objective is to train at least one person in every family in procedures to meet their health needs during a national emergency if deprived of a physician.

Training kits containing materials necessary to teach the course have been distributed through the State Health Department, and the program is administered under the combined sponsorship of the State Health Department, Office of Civil Defense, the KSMA Committee on Emergency Medical Services, and Department of Education.

The State Health Department works with local medical societies and local civil defense officials in a training program to orient local medical and allied medical personnel in their role during a disaster. At the present time, a course for environmental health personnel is being developed and will be held in local communities to teach their expanded functions during an emergency.

All of the above mentioned programs are being presented to local communities for the purpose of assisting all medical and allied medical groups to function efficiently during a disaster.

Coordinated Program

The State Health Department has the responsibility to develop a coordinated emergency program for agencies having health or related responsibilities. Emphasis from this agency is placed on the development of realistic emergency plans, organization of health resources, assignment of responsibility for each aspect of emergency health activity, practice in emergency procedures, and training and evaluation in preparedness operations. These procedures, with the cooperation of the State Medical Association, county medical societies, and the civil defense organization are the basis of a health preparedness plan being written for each community so that they may better utilize their resources during a national emergency. It is imperative that all medical and allied medical groups throughout the State of Kentucky cooperate to the fullest extent in assisting the State Health Department in accomplishing these plans. Without their cooperation and consent, the State Health Department will be unable to implement the emergency health activities which would be such an important need during a national emergency.

The Organization Chart

for the

KENTUCKY STATE MEDICAL ASSOCIATION

Revised as of January 1

Is on Page 88

The Civil Defense Emergency Hospital in Kentucky

FRANK REIDER, M.D.,* AND FORREST D. STOKES, A.B.**

Washington, D.C., and Frankfort, Ky.

THE 200-bed Civil Defense Emergency Hospital (CDEH) stockpiling program was initiated in recognition of the fact that an all-out attack on this country with nuclear weapons could result in a great disparity between the number of people requiring hospital care and available beds to provide such care. Not only would the number of sick and injured be vastly increased but it is estimated for planning purposes that approximately one-half of the approximately 7,000 existing hospitals with almost 1.7 million beds would no longer be available because of damage.

To meet the post-attack needs within the estimated surviving professional staff it is estimated that 9,500 CDEH's would be required, strategically prepositioned outside of probable damage areas throughout the country. To date, 1,930 CDEH's have been allocated to the states.

The 1953 version of the CDEH weighed about 13½ tons, occupied 2,000 cubic feet, cost about $26,000, and contained about 285 line items. The expendable items would be available from two to four days depending upon the patient load. Replacements would come from Federal depots. The expected life of the unit was about three weeks. Later models of the CDEH were revised in 1954, 1956, and 1957, certain items being discarded and others added. The 1962 model has been revised extensively, based on recent planning standards relating to nuclear weapon attacks. This has been expanded to a thirty-day supply of consumables and a unit life of a year or more. Line items have increased to 688, cost to $45,000, weight to 25 tons, and storage to 7,280 cubic feet. In 1964, 750 CDEH's of the 1962 model will be distributed to the States. In addition the present prepositioned hospitals will have additions made to them to bring them up to the 1962 CDEH capability.

Of the existing prepositioned CDEH's, 100 have been used by the States as training hospitals. While serving certain good purposes, and subject to many modifications in the several States, they are admittedly too bulky and unsuited for training purposes. A new training unit designed to overcome most of the shortcomings, objections, and bulk of the 1953 CDEH training hospitals is being perfected, and ten such units will be sent to selected States for further testing and training during the present year.

In Kentucky 26 CDEH's are strategically located in readiness for aiding casualities in the event of a major disaster.

In addition to the 26, there is one CDEH presently located at the State Department of Health in Frankfort which is being utilized for community training.

Through the Health Mobilization program of the State Department of Health and with the cooperation of Civil Defense personnel, medical officials, hospital staff members, and other technical and non-technical personnel are being trained in the procedures of setting up and operating these emergency hospitals.

If a training demonstration is desired, the civil defense medical staff finds a suitable location and contacts the Director of Health Mobilization at the State Department of Health. When the request is granted, details of the demonstration will be worked out by county civil defense officials, their medical staff, and the Director of Health Mobilization.

The training unit is a representative portion of a 200-bed unit and contains the principle working elements of a CDEH. To date, there have been training demonstrations at Louisville, Paducah, Bardstown, and Henderson.

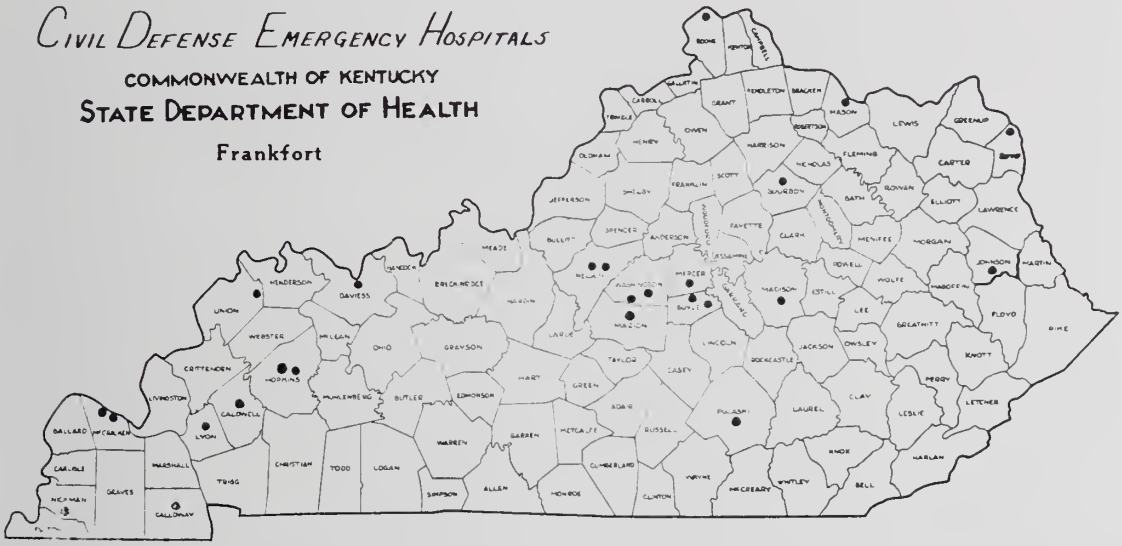
Guided by the Commissioner of Health, the Director of Health Mobilization developed Kentucky's CDEH program. His major concern is the prepositioning, inspecting, and updating

* *Chief, Training Branch, Division of Health Mobilization, Office of the Surgeon General, U.S. Public Health Service, Washington 25, D.C.*

** *Director, Civil Defense and Health Mobilization, Kentucky State Department of Health, Frankfort, Kentucky.*

of the CDEH's. The director's responsibilities include correcting all deficiencies of storage facilities and conditions reported by the Inspection Team of the U. S. Government's General Services Administration, making certain that the CDEH's are ready for immediate use in the event of an emergency, and updating and upgrading all CDEH's to a thirty-day operational capability.

The State Department of Health with Civil Defense officials and the Kentucky State Medical Association Disaster Committee is preparing a model guideline medical disaster plan. These guidelines will assist local communities in writing specific health plans for their utilization of the CDEH and assignment of medical and allied-medical personnel at the local level. This plan should be kept current, and the State Department of Health notified of any changes.



*Kentucky

Civil Defense Emergency Hospitals

Location	Custodian
Ashland, Ky. Our Lady of Bellefonte Hosp.	Hans J. Daniels Our Lady of Bellefonte Hosp. Ashland, Ky.
Bardstown, Ky. Vocational Building Bardstown School	Frank Watts Bardstown School Bardstown, Ky.
Berea, Ky. Am. Legion Building	Roy Walters Dean of Foundations Berea College Berea, Ky.
Clinton, Ky. City Hall N. Washington St.	Tony Harpole 116 N. Jefferson Street Clinton, Ky.
Danville, Ky. (2) Ky. State Hospital	A. M. Parks Kentucky State Hospital Danville, Ky.
Falmouth, Ky. Old Buick Garage	Melvin Hart Second Street Falmouth, Ky.
Florence, Ky. Administration Building Greater Cincinnati Airport	Otha Gaines Maintenance Mgr. Greater Cincinnati Airport Florence, Ky.
Harrodsburg, Ky. Corning Glass Works Warehouse Louisville Road	George Shiners 116 Montrose Harrodsburg, Ky.
Henderson, Ky. Old Post Office Main & 3rd Sts.	Charles Kessinger, M.D. 700 N. Elm Street Henderson, Ky.
Kuttawa, Ky. Route 4	Eugene Denning Fairview Avenue New Eddyville, Ky.
Lebanon, Ky. Old City Hall Proctor Knott Avenue	J. T. Whitlock 224 N. Spaulding Avenue Lebanon, Ky.
Madisonville, Ky. (2) National Guard Armory Park Avenue	Captain Garland Pence 23 North Harrig Street Madisonville, Ky.
Maysville, Ky. Washington High School	Lillian Wallingford Maysville, Ky.
Murray, Ky. Rear of County Library 105 North Sixth Street	James Lassister Murray Ky.
Nazareth, Ky. Nazareth College	Mother Lucille Nazareth College Nazareth, Ky.
Owensboro, Ky. National Guard Armory 1501 Parrish Avenue	James W. Cooper City Hall Owensboro, Ky.
Paducah, Ky. (2) Civil Defense Yard on trailers 2000 Meyers Street	Franklin C. Still 905 N. 24th Street Paducah, Ky.

continued on page 46

You, Your Hospital, and Disaster Planning in Kentucky

Ben R. Brewer.* and William B. Haley. M.D.**
Paducah, Ky.

IN TIMES of peace as well as in warfare the hospitals and their staffs are called upon to render emergency medical care. Under ordinary circumstances this care is rendered to a few patients at a time and there are arrangements for this service in all such institutions. However, because of the increased probability of a large number of patients being involved in a mass emergency, whether of natural causes or man made, either accidental or deliberate, it behooves us as hospital administrators and physicians to make plans for the utilization of our facilities and services on a greatly expanded scale before we are faced with the problem.

We feel that such programing falls into three major categories. These are: 1) The Master Disaster Plan of the hospital which includes procurement of additional supplies and equipment, which will be discussed in more detail later, 2) The training of the hospital personnel, and 3) the physicians' duties. All of these items would be included in the Master Disaster Plan of the hospital which as you know is required by the Commission on Accreditation for full accreditation. Unfortunately, many of these plans are inadequate, ill conceived, and unavailable except to the administrators. A checklist for hospital disaster planning has been prepared by the American Hospital Association and the American Medical Association and will soon be available as a guide for preparing each individual hospital.

The responsibility of training the hospital personnel belongs to the hospital administrator with the assistance of the medical staff. Every employee should be given a course of the Medical Self-Help Program, specifically for instruction of lay people by lay people. In addition to this, a first aid course which is an extension of the medical program would be advisable. This course may be obtained from the civil defense director in each area or Mr. Forrest Stokes, coordinator for the Civil Defense of the Department of Health, Education, and Welfare in this state. These courses give each employee valuable information for use in a mass emergency, or every day life. In addition to the training in these specific fields each should be taught his duties in the over-all plan for the operation of the hospital on an emergency basis.

We feel that physicians should operate under these circumstances on a quasi military basis. Should the community have more than one hospital, a chief of medical personnel should be appointed by the County Medical Society to direct the activities of physicians. Each staff should have a chief who should be chief of staff of that hospital and have as his responsibility the assignment of staff members to various work areas. The appointment should be based on the ability of the individual.

The most important and most difficult job will be that of triage. This requires good judgment, quick decision, and a broad knowledge of trauma. It is recognized that there will be an inadequate number of physicians to take care of the large number of casualties involved in a mass disaster and therefore, delegation of responsibilities to registered nurses who have had additional experience will be necessary.

As for utilization and supply of hospital facilities, the following suggestions are considered of great importance.

Utilities

Utilities are probably the most important items of supply. Electricity and water when not available can drastically curtail all disaster efforts. Nearly all hospitals have emergency power plants which can take care of minimal electricity needs. Some hospitals have an auxil-

* *Mr. Brewer is Hospital Director of Western Baptist Hospital, Paducah, & president-elect of the Kentucky Hospital Association.*

** *At the time this article was written, Doctor Haley was a member of the KSMA Emergency Medical Services Committee.*

iary water system. Milk trucks can be quickly called into action to haul water to the hospital from other sources.

Nursing Supplies

Nursing supplies probably constitute the next most important category. It is obvious that one hospital would soon exhaust its supply of dressings, plasma, etc. Under these circumstances it is necessary to call neighboring hospitals, wholesale houses, retail outlets, Civil Defense and Red Cross for additional materials. When the hospital has kept an up-to-date disaster plan and periodically reviewed the plan there should be no difficulty in convincing the usual sources of supply and industries that the hospital's needs must come first.

Emergency Feeding

Emergency feeding includes the responsibility of supplying food to the most needed, for the care of the injured, fire-fighters, rescue crews, etc., as well as the responsibility of maintaining the nutritional balance of the persons injured by the disaster. In addition to supplying necessary calories, emergency feeding helps morale and avoid panic. During the first 48 hours after a major disaster, the only essential for the maintenance of life is water. In the event water could not be supplied through a city system, urgent needs could be met to a limited extent by using distilled water manufactured in the hospital.

It has been found that the supply of food maintained in most hospitals would be adequate for approximately five days during a disaster. By working through community groups food procurement for hospitals would be given priority and in all probability adequate supplies could be obtained through the companies now serving the hospital. A program or order of feeding should be established.

Radiology

The radiology department presents some unique problems. It is entirely possible that the major electric power services would be out of operation and only X-ray units which operate from 12 volt sources could be used. In the absence of a 120 volt power service, a gasoline driven motor generator set of three to five horse power could be used to operate the units. The department's reserve supply of films and chemicals should be maintained.

Laboratory

The laboratory's most outstanding responsibility would be the collection, preparation, and storage of blood. Most of the laboratory procedures except the basic blood count and urinalyses could be discontinued in an effort toward preparedness in anticipation of any disaster.

Drugs

The hospital's pharmacy or drug room should attempt to maintain a months inventory of all possible emergency medications for patients. Such drugs should include narcotics, antibiotics, anesthetic agents, etc. Provisions for supplementary medications should be made with pharmaceutical houses and drug wholesale houses.

Linen

The usual laundry department can handle 20% to 25% more linen than is usually used. Requirements over this will necessitate procuring linen from outside sources. Arrangements can be made with commercial laundries, who undoubtedly would be willing to offer their help in an emergency.

Hospitals As Shelters

The American Hospital Association and the Office of Civil Defense, the Department of Defense have recently agreed on a policy calling on hospitals to serve as public fall-out shelters during the first phase of an atomic attack. There has been a good deal of confusion and subsequent concern about this agreement. Hospitals are now being surveyed for their use as fall-out shelters. Whatever space is made available is to be used for patients within the hospital and the personnel in the hospital who care for those patients. Only after all these requirements have been met, will space be made available for the general public. It is conceivable that in some hospitals there will be no space actually available for the general public. Nonetheless, these fall-out shelters will be stocked by the Federal Government because they will be serving as shelters for patients and hospital personnel.

Informal organization and planning during disaster can influence the success of the hospital's program. But success depends to a very great extent upon the amount of previous planning done.

The Red Cross And Disaster Planning

DARRELL HOUSE*
Frankfort, Ky.

"We in the medical profession have become accustomed to the excellence of Red Cross work in time of disaster, in safeguarding the lives and health of the American people through its blood program, in teaching first aid, in instructing water safety to our youth, and in contributing to community health projects."

Leonard W. Larson, M.D.
Past President, American
Medical Association

WHEN DISASTER strikes a community, one of the first organizations to respond to the needs of the affected people is the American National Red Cross and its chapters through their disaster preparedness committees. Among the many unique disaster services, seldom heralded but always available, are supplemental nursing and medical assistance, including supplies of vital blood, and emergency first aid assistance.

On May 21, 1881, the American National Red Cross was established, designed not to provide charity, but to help people to help themselves. The early years of the organization were devoted almost entirely to providing emergency disaster aid to individuals and families; extension of the program to include help with repair and rebuilding of owner-occupied homes, replacement of furniture and furnishings, and other long-range assistance developed over the intervening years. All disaster assistance is given as a *gift* from the American people through Red Cross and is not to be repaid.

Acting under Congressional authority, the American Red Cross is a quasi-governmental organization. However, its role in disaster relief cannot be construed as such an exclusive delegation of power by the federal government as to invade, encroach upon, or substitute for the authority and responsibility of federal, state, municipal, and other local governments to provide assistance to their people in time of disaster.

Government responsibility in disaster remains the same as in normal times—the protection of life, property, public health and welfare, and the maintenance and repair of public property. Red Cross assistance to families supports and assists the work of government and its agencies in alleviating the distress caused by disasters, but does not assume responsibility for governmental functions. The following chart shows the respective responsibilities of the Red Cross and governmental agencies in disaster.

The American Red Cross First Aid Service, since its introduction in 1909, has had as its single objective the conservation of human life through the prevention of accidents including those in time of disaster.

The backbone of Red Cross educational programs in first aid, small craft, and water safety is a corps of volunteer instructors trained in chapters, national aquatic and small craft schools. All of these programs are available to individual citizens and for Civil Defense training through most of the local Red Cross chapters scattered through the United States. Instructors as well as trained graduates of these programs are also available for volunteer disaster service on emergency teams.

A question often asked of the American Red Cross concerns the Medical Self-Help program and the organization's participation in the program. The medical self-help program is designed to provide information to the people of the United States that will prepare them for survival by using their own knowledge in a time of national disaster. This program, developed by the Public Health Service and the Office of Civil Defense in cooperation with the American Medical Association, Council on National Security and Committee on Disaster Medical Care, is based on the premise that in time of military disaster families may not have medical assistance, normal food sources, water supplies or sanitation facilities and may need to sustain themselves in a shelter environment for an extended period of time.

The American National Red Cross has been requested by the U. S. Public Health Service,

*Field Representative, American Red Cross, Frankfort, Ky.

Department of Health, Education, and Welfare, and the Office of Civil Defense, Department of Defense, to assist in providing to the public information necessary for survival.

In cooperation with Civil Defense and medical and health authorities, Red Cross volunteer first aid and nursing instructors in many Kentucky communities offer four units of the Medical Self-Help program as a supplement to individuals who complete the Red Cross standard first aid course.

The additional units taught include radioactive fallout and shelter, healthful living in emergencies (hygiene sanitation and vermin control, water and food), nursing care of the sick and injured, infant and child care, and emergency childbirth. The units are presented with the assistance of physicians and specialists in the subjects representing various community organizations.

There is no evidence that the Red Cross role in disaster will be altered in the forseeable future. The American National Red Cross and its chapters will continue to work in disaster preparedness on all levels and be ready to act both in time of natural disaster or national emergency.



Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Medical Education for National Defense Emphasized At Kentucky's Two Medical Schools

At the University of Louisville we have adopted the following method of presenting Medical Education for National Defense:

To alert all the students beginning with the Freshmen to the importance of the medical problems inherent to disasters and to emphasize the necessity for each of them to learn the fundamentals of survival care in the case of disaster, the following subjects are stressed: Emergency Care of Hemorrhage, Resuscitation, Shock, Sorting, Burns, Fractures, Trauma, Radioactive Fallout, Self-help, and Public Health. Disaster Medical Care at a higher level is integrated into the lectures given our third and fourth year students by faculty members, most of whom have attended MEND symposiums.

We present as part of the regular medical school curriculum during the Freshman and Sophomore years courses definitely pertinent to MEND. The Freshman course consists of six hours, the Sophomore course eight hours. I believe we have succeeded in lifting these courses above the level of what is designated as "first-aid." We feel this is very important. The success of the courses, I am sure, is due to the presentation of each subject by a senior member of the faculty. We have had no difficulty in obtaining cooperation from the faculty in the teaching of the subjects.

We are continuing as we have for the past six years to give each Freshman a copy of the manual, *Emergency War Surgery,* at the beginning of the course in Disaster Medicine. This manual, which is an emergency surgery handbook compiled for use by the NATO nations, is used as a text.

MEND funds provide us monies to obtain guest speakers on any subjects pertinent to MEND. We have not obtained many speakers during the past year or two. Instead, we have preferred to utilize the available funds for faculty travel to sponsored symposiums relevant to MEND. We do intend within the next year to have perhaps a symposium on Trauma or some related subject.

As aids in our teaching, we use a great many films from the Armed Forces and from private sources. These movies we show not only to the students but also to the nursing staff. We feel they are of great value.

We have purchased several thousand dollars worth of books for the library. We have also purchased for teaching purposes a manikin, "Resusci-Anne." We have found her to be of value in teaching mouth-to-mouth breathing and cardiac massage to the medical students, the nursing staff, and ancillary personnel. We have loaned this manikin to the Boy Scouts and Police Department for the instruction of their personnel.

This year for the first time we demonstrated the Medical Self-Help training kit provided by the Public Health Service, not so much to teach the students per se, but we believe this to be a very good method for the student to know that such a kit exists. Now with this knowledge, the students returning home during their vacations will stimulate some interest in medical self-help at community level. Each county in Kentucky has a minimum of one kit furnished by the public health department for community use. This method of teaching is a valuable addition to a first-aid course, since first-aid treatment is predicated upon the fact that a doctor will be immediately available, while self-help teaching is predicated upon the fact that there will be *no doctor immediately available.* In the event of a national disaster, the latter will be the fact.

We firmly believe that if members of the faculty are not interested in the MEND Program, the students will be even less interested. For that reason we are making great efforts to send different members of the faculty to the symposiums and courses given by the Medical Services of the Armed Forces, the Public Health Service and the Armed Forces Institute of Pathology. This is a very important part of the MEND Program, and we have found that many of the faculty members are enthusiastic about participating.

Following is a partial list of the subjects presented at the symposiums and courses that our faculty members have attended recently: *Infections Diseases in Biological Warfare and Global Medicine,* (Walter Reed Army Institute of Research, Washington, D.C.); *The Medical Aspects of Missiles and Rockets,* (Patrick Air Force Base and Cape Kennedy, Florida); *Radiological Defense and the Treatment of Radiation Injury,* (National Naval Medical Center, Bethesda, Maryland); *The Pathology of Radiation Injury,* (Armed Forces Institute of Pathology, Washington, D.C.); *Surgical and Orthopedic Aspects of Trauma,* (Brooke General Hospital, Fort Sam Houston, Texas); *Management of Mass Casualties,* (Brooke Army Medical Center, Fort Sam Houston, Texas); *Lectures in Aerospace Medicine,* (USAF School of Aerospace Medicine, Brooks Air Force Base, Texas); *Medical Aspects of Stress in the Military Climate,* (Walter Reed Army Institute of Research, Washington, D.C.); *Organizing Emergency Health Services,* (Public Health Service, Dallas, Texas); *Medical Aspects of Nuclear Energy,* (Defense Atomic Support Agency, Sandia Base, New Mexico); *Medical Aspects of Tropical Operations,* (U. S. Army, Navy, and Air Force, Panama Canal Zone).

In addition to faculty travel, we send three senior residents each year to the course in *Management of Mass Casualties* at Brooke Army Medical Center.

We maintain a military counselling program for medical students. This has been quite successful. We think we have helped the students to obtain internships and residencies in the Armed Forces, if they so desire. We also stress the importance of participation in the Berry Plan as a means of obtaining residency training prior to fulfilling their military obligation.

We make every effort to impress on the students that mass disaster is a *medical problem.* Should

mass disaster occur, the civilians will be the ones to suffer the vast majority of the casualties. We can depend upon no one but ourselves to do the job with minimum help, a minimum amount of supplies, and with little help from the Armed Forces, since they will be occupied elsewhere.

Hobart D. Belknap, M.D.
MEND Coordinator
University of Louisville
School of Medicine

MEND Program Activities At the University of Kentucky

The MEND program at the University of Kentucky Medical Center was originally initiated in an orientation phase in 1960, and our contract has been renewed annually since that time. MEND activities at the Medical Center may be classed under three broad headings: 1) MEND sponsors symposia and speakers in MEND subjects, 2) MEND material is incorporated in the medical school curriculum, and 3) MEND has sponsored the procedure to be carried out in the event of a disaster.

A MEND-sponsored symposium on "The Physicians's Responsibility in the Event of Thermonuclear Disaster" was held at the Medical School on December 7, 1961. The following speakers gave excellent talks pertinent to their fields of interest:

Solomon Garb, M.D.—"Principles of Individual Protection"; Carl L. Hansen, Jr., M.D.—"Acute Radiation Effects"; Lt. Col. Francis W. Lanard—"The Medical Problem in Nuclear Weapon Warfare and Methods of Containment"; George Moore, M.D.—"The Role of the County Medical Society in Organization of a Civil Defense Program: Training of Professional and Non-Professional Medical Personnel"; John W. Raker, M.D.—"Experience with Mass Casualty Management in Civil Disasters"; Joseph R. Shaeffer, M.D.—"Thermal and Blast Effects"; Frederick Stohlman, M.D.—"Early Detection and Treatment of Radiation Injury."

The symposium was attended by students, faculty, and many physicians from throughout the state. Considerable interest was generated regarding the effects of a thermonuclear explosion on the population and measures which might be taken to minimize these effects.

Speakers sponsored by the MEND program have included: Lars-Erik Gelin, M.D., Department of Surgery, University of Gothenburg, Sweden—"Plasma Substitutes Following Trauma"; Milton S. Sacks, M.D., Professor of Clinical Medicine, University of Maryland School of Medicine, Baltimore—"Principles of Blood Typing and Transfusion"; Professor A. W. Badenoch, Chairman of the Department of Urology, St. Bartholomew's Hospital, London, England—"Management of the Injured Urethra"; and Horace E. Campbell, M.D., Denver, Colorado—"Automobile Injuries and Safety."

The major innovation in MEND related activity at the University of Kentucky Medical Center for the year 1962-63 was the planning of a disaster procedure. A preliminary disaster procedure was set up by Ben Eisenman, M.D. and a practice drill was held. In 1962, the faculty, students, and other personnel participated in this exercise, which covered a 24-hour period. Following the drill a critique was held. It was felt that a much more realistic disaster procedure could be set up, having been through a practice drill. A second practice drill was held in October, 1963.

Subsequently, we have published a small 40-page booklet, *University of Kentucky Medical Center Hospital Disaster Procedure,* which has been distributed to those who will be involved in patient care in the event of a disaster.

The principles of optimum care of mass casualties as set forth by the booklet are outlined as follows:

1. Disciplined central control.
2. Regulated communications and transportation (Stay off elevators and telephones).
3. Hospital use for casualties only. (Rigid external traffic control. Exclusion of all families, curious and unassigned well-meaning volunteers.)
4. A single portal of entry for all casualties where triage is quick and efficient.
5. An emergency record system, which will accompany the casualty, will identify him, record his clinical status, and will provide sufficient data to a remotely located information center where relatives and the press will be satisfied.
6. Sensible stockpiling and availability of essential supplies.
7. Professional personnel who are accustomed to taking care of the injured.
8. Shock or preoperative wards.
9. A pool of semi-professional (Medical and Dental students) personnel and of non-professional volunteers for on-call assignments.

MEND related subjects have been integrated into the curriculum in a number of courses where appropriate. The Department of Radiology offers a course on the biological effects of radiation. A prize is offered to the student submitting the best essay on "The Point of View of the Physician as an Advisor to the Family in Matters Concerning Radiation."

The Department of Surgery offers a course to the second year students on the principles of management of traumatic wounds.

The Department of Anesthesia is preparing a course on the techniques of emergency respiratory and cardiovascular resuscitation techniques.

Madison J. Cawein, M.D.
MEND Coordinator
University of Kentucky
College of Medicine

Disaster Medical Care Committee Reports From County Societies

Approximately 30 county societies have reported that they have committees organized in the field of disaster care. The following reports were received from some of these county societies.

Boyd County Medical Society

The chairman of the Boyd County Medical Society's Emergency Medical Services Committee is Paul R. Kleykamp, M.D. The Committee has completed a course for instructors in Medical Self-Help. These instructors are volunteers and they in turn are conducting classes on a voluntary basis. There are two hospitals in Ashland, both of which have disaster plans. Ashland also has a two-hundred bed portable hospital stored and available for use.

Fayette County Medical Society

The efforts of the Fayette County Emergency Medical Services Committee have been directed toward civilian disaster at a local level. The staffs of the four participating hospitals in Lexington have been organized on a disaster basis. Three teams of physicians have been appointed for each hospital. A master list of the teams is to be readily available at each hospital in a communications center. Each hospital has its own disaster plan within which these units or teams will work. It is recommended that casualties be dispersed between the four participating hospitals in such a fashion as to minimize over-loading of the facilities of any one institution. To facilitate this, the number of casualties will be estimated as early as possible by the local police and fire departments according to a predetermined schedule, that is, twelve to twenty-five—Disaster 1, twenty-five to fifty—Disaster 2, etc. The chairman and vice-chairman of the committee and the hospitals will be notified of the type of disaster. Medical staffs will be re-organized as indicated and arrangements are being made for some projected "dry runs" to the various institutions. The chairman of the committee is Andrew M. Moore, M.D., and the vice-chairman is Edward Rankin, M.D. Other members are Richard McElvein, M.D., W. T. Swartz, M.D., and Richard Floyd, M.D.

Garrard County Medical Society

Mr. Emil Gleich is director of the Garrard County Civil Defense. At the present time, eight people are qualified to teach the American Red Cross First Aid course. Twenty-six individuals hold Advanced cards and fifty-eight hold Standard cards. A practice exercise including a simulated accident has been completed. The First Aid Chairman is Mrs. Dolores Gleich.

Graves County Medical Society

The Graves County Medical Society is taking part in the Red Cross Disaster Policy. The Graves County Chapter of the Red Cross Disaster Plan was organized in the latter part of 1962 and the various committees and sub-committees were appointed at that time. Printed copies of the disaster plan were distributed to all committee members at the last meeting and discussion was held on how the various committees would operate in relationship to local Police, Fire Departments, housing and shelter, evacuation, medical and nursing care, communications, and the relationship with civilian defense committees and various government agencies. It is anticipated that a meeting will be held each six months to review plans, replace committee members as necessary, and to discuss points or procedures that will help in the preparation for a disaster. Chairman of the Medical Sub-committee is Donald C. Haugh, M.D. The Vice-Chairmen are J. Steele Robbins, M.D., Jacob Mayer, M.D., and Harry M. Roach, M.D. The other members of the Graves County Medical Society will aid in supplying treatment to injuries, supervise the sanitation of the temporary shelters and kitchens, and assist in public health measures as necessitated by the particular disaster that may occur.

Mason County Medical Society

The Maysville-Mason County Civil Defense Organization, approximately five years old, has several plans to go into effect according to the type of disaster. Plan "A" was set up for a small disaster, twenty-five to fifty casualties, and physicians, nurses, aides, clerks, pharmacists, etc., are assigned to report to various centers. Plan "B" is similar to Plan "A" except casualties would number fifty to one hundred and more personnel and centers (buildings, etc.) would be involved. Whenever Plan "A" or "B" is to go into effect, notification of personnel and where they are to report is made by telephone operators who keep an up-to-date list. The Medical Director notifies the telephone operators. Plan "C" is an all out alert and casualties would be received from nearby major disaster areas. Various buildings have been designated to receive evacuees and assign injured accordingly. Personnel have been assigned to various locations and will be notified by numerous sirens throughout the town. A 200-bed Emergency Hospital is stored here. George E. Estill, M.D., is Medical Director and W. H. Cartmell, M.D., is Medical Co-Director. Director of Pharmacists is C. R. Kilgus and Director of Nurses is Marjorie K. Waddell, R.N.

Perry County Medical Society

Donald L. Martin, M.D., is chairman of the Emergency Medical Services Committee of the Perry County Medical Society. The Committee has sponsored the teaching of the course—Medical Self-Help—to the high school students in the area, and has conducted a one-day seminar on Emergency Medical Services for all medical personnel in the county.

They have also offered First Aid lists for fall-out shelters through the newspaper and radio media.

Pike County Medical Society

There are a total of 23 physicians who are participating in the Pike County Emergency Disaster Program. G. N. Combs, M.D., is the Hospital Chairman and the Field Chairman is E. I. Rustin, M.D. The other physicians serve in either Stand-by Emergency Surgery, Emergency G.U., Emergency Medical, Emergency Field Work, Emergency E.N.T., or Emergency O.B. Should an emergency arise, all of the doctors will report to the Methodist Hospital immediately.

Pulaski County Medical Society

The Pulaski County Medical Society reports a very complete disaster plan and every physician of the county has his assigned post and work to be done in the event of any type of disaster. The nurses and the non-professional personnel of the hospital also have assigned duties in case of an emergency. The plan establishes a definite chain of command with alternatives designated for key positions if the need arises for alternates. Attempts have been made to tie in closely the plan of the Pulaski County Medical Society's Emergency Medical Services Committee with the Disaster Planning Committee for the Somerset City Hospital and with the Civil Defense Plan for the Community. A "dry run" of the disaster plan is scheduled for the near future to see how smoothly the plan will operate and to better acquaint everyone with their assigned duties. The Emergency Medical Services Committee Chairman is Elmer R. Smith, M.D. Other Committee members are C. R. Faulkner, M.D., B. L. Ramsey, M.D., and E. T. Smith, M.D.

Daviess County Medical Society

The Daviess County Medical Disaster Committee has been in existence for more than ten years. It consists of a plan for care of national medical emergencies which its key assignments named accordingly. A major portion of the doctors and dentists are in a pool for assignment purposes. Each hospital has its own plan dove-tailed into an over-all plan. It is coordinated with local civil defense and law enforcement agencies. All major industries and transportation facilities have been notified of its existence. The plan has actually functioned on one occasion about five years ago with an airplane accident which involved some 20 passengers and crew members. Local law enforcement personnel sealed off the area and the triage team was present as the victims were evacuated. The hospital was alerted and handled the problem smoothly and efficiently. One mock alert was conducted about three years ago. There is a 200 bed emergency hospital stored in the community under the direction of the City Civil Defense Director and it is felt that it should be drawn into the next alert. All the committee members have had military experience. They are: John Dixon, M.D., Charles E. Hornaday, M.D., and Howell J. Davis, M.D., Chairman.

Hardin County Medical Society

David T. Lewis, M.D., Elizabethtown, has reported that a 200-bed emergency hospital is expected to be located in Hardin County as a part of their current Civil Defense Planning. The medical self-help teaching program has been initiated and the Second Annual Medical Civil Defense Program has been completed. Approximately 40 doctors, nurses, and allied personnel attended the program and heard Douglas LeNeave, M.D., Louisville, speak on the fall-out problem in the Hardin County area. The Hardin County Medical Society is now making plans to assign a staff to the emergency hospital to activate it in the event it is ever needed.

Flying Physicians Association To Assist in Emergency

The Flying Physicians' Association, organized nationally about seven years ago for the promotion of safety and mutual interest in aviation within the medical profession, has developed into a tremendous asset to the American Public as well.

Under the able leadership of Mark DeGroff, the national organization flourished, with the publication of a monthly bulletin on the medical aspects of aviation and the establishment of an annual meeting.

Shortly after organization on the national level, active state chapters were set up, as was the case in Kentucky. Some 66 Kentucky physician-pilots banded together to hold regular meetings concurrent with the KSMA Annual Meeting, plus fly-in breakfasts.

Not long after the organization was developed, the members realized that the FPA was a potential asset to the American people in time of emergency.

In the event of a civil disaster in which approximately one-fourth to one-half of the civilian population were lost, it is a similar possibility that a comparable percentage of the medical personnel would be involved. This could leave any isolated region without sufficient medical or paramedical personnel when they are needed most. In such circumstances it is recognized that medical help would have to come from an outside source. Usually it must come from a considerable distance and must be available despite the destruction of highways, or other usual methods of transportation.

There are approximately 2,000 FPA members in the United States, the majority equipped with their own four-passenger airplanes. This would mean that as many physicians as planes, and, assuming one or two paramedical personnel to a plane, could be mobilized within a short time.

All of the planes are on a ready basis and due to their operating characteristics, available airports would not be a necessity, as landing strips could be fashioned out of available blocked-off sections of highways or suitable fields.

In Kentucky at this time there are approximately

30 registered members of the FPA, though some 70 physician-pilots are known. It is speculated that within a period of approximately two hours about 30 equipped physicians, 60 paramedical personnel, and equipped planes could be anywhere in the state.

The organization has an organized disaster program in which each physician in the country is numbered and given a subsequent physician to call in the event of a natural disaster. By referring to the directory of the Flying Physicians which is in the hands of our civil defense authorities, any number of physicians of any known specialty can be mobilized on short notice.

For several years there was a lack of interest in the FPA by the civil defense authorities. Consequently the local association was inactive with regard to disaster control and aid. However, during the past two years a very active civil defense organization in the state and within the state health department has revived interest in the potentiality of these physicians, and organization efforts for the state chapter are again under way.

Shortly after the publication of this Journal we hope to hold a reorganization meeting to strengthen individual plans in the event of a civil disaster. All active members will be notified of the meeting at that time. Any physician in Kentucky, whether or not you fly, if interested in becoming a member of this organization, either on an active or stand-by basis, is requested to contact George M. Gumbert, M.D., 2101 Nicholasville Road, Lexington, or C. Douglas LeNeave, M.D., 315 East Broadway, Louisville.

In spite of the re-organization attempts, there are at this time 30 Flying Physicians in Kentucky ready to assist in a civil disaster at short notice.

Emergency Hospitals—Reider & Stokes

Continued from page 37

Saint Catharine, Ky. **Administration Building** **St. Catharine's Academy**	**Mother Mary Julia** **St. Catharine's Academy** **Saint Catharine, Ky.**
Somerset, Ky. **RECC Building**	**Sam Hord** **Manager, RECC** **Somerset, Ky.**
Springfield, Ky. **School Bus Garage Building** **St. Rose Priory**	**Father Shearer** **St. Rose Priory** **Springfield, Ky.**
Paintsville, Ky. **Mayo State Voca. School** **307 Third Street**	**George L. Ramey, Director** **Mayo State Voca. School** **Paintsville, Ky.**
Paris, Ky. **Nurses Home** **State Tuberculosis Hospital**	**Robert W. Walker** **State Tuberculosis Hospital** **Paris, Ky.**
Princeton, Ky. **Rear of Princeton Cream Co.**	**Frederich Olszewski** **Court House** **Princeton, Ky.**

Emergency Medical Identification For Special Problems

A universal symbol which will tell anyone rendering emergency care that its wearer has a condition requiring special attention was approved at the last Annual Meeting of the American Medical Association.



The symbol may be displayed on a bracelet, anklet, necklace, or elsewhere. The symbol is an indication that there are vital medical facts on a personal health information card in the bearer's wallet or purse.

The symbol is a hexagon-shaped emblem containing a six-pointed figure, or sign of life. Superimposed on the figure is the staff of Aesulapius, the insignia of the medical profession.

The symbol will be used by many individuals. It will indicate allergies to antibiotics; diabetes; and many other physical problems.

For information on obtaining these devices, contact the KSMA Headquarters Office.

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

A Lupus-like Syndrome Following Propylthiouracil Administration

Maurice M. Best, M.D.* and Charles H. Duncan, M.D.**

IN THE management of a patient with thyrotoxicosis, the physician must choose among an antithyroid drug, thyroidectomy or radioiodine. In our opinion, antithyroid drugs are the initial choice in a young patient with a moderately enlarged and smooth thyroid gland associated with moderate hyperthyroidism. Recently we encountered an interesting, but alarming, reaction in such a patient while under treatment with propylthiouracil; the patient was later treated with methimazole (Tapazole) without ill effect.

Report of a Case

M. F., a 17-year-old Negro female, was first admitted to the Medical Service of the Louisville General Hospital because of a painless swelling of the neck and extreme nervousness. She first noticed episodes of irritability, tremor of the hands, heat intolerance, and profuse perspiration following the birth of her child three years previously. During the past six months the symptoms had been constantly present and had been accompanied by increased appetite.

On physical examination, the patient was hyperactive but cooperative. The skin was moist and warm. The thyroid gland was about three times normal size and was smooth and nontender. A fine tremor of the hands was present and the fingernails had a characteristic separation of the fistal nail from its bed. The pulse rate was 130 and the respiratory rate was 24 per minute. The blood pressure was 120/70 mm. Hg, and the oral temperature, 99°F.

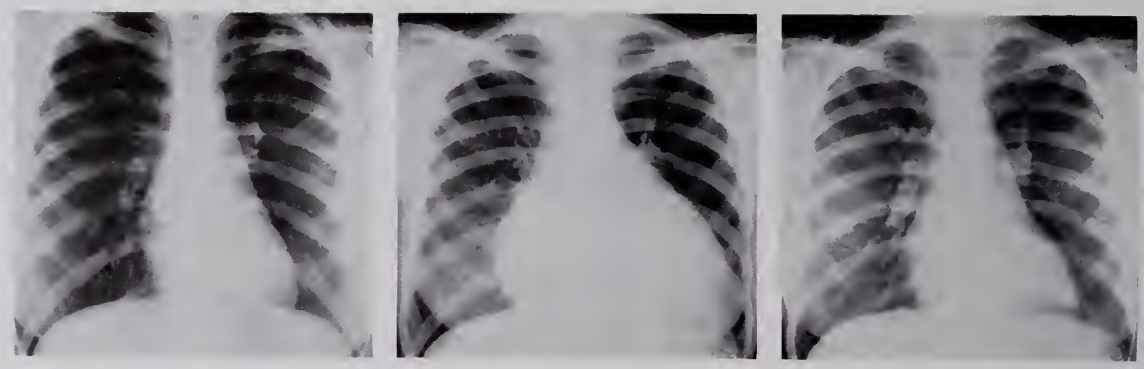
All laboratory studies were within the range of normal except those pertaining to thyroid function. The radioiodine uptake by the thyroid gland was 80 per cent 24 hours after the administration of 47 microcuries of I^{131}. Protein bound iodine was 12 micrograms per 100 ml. The photomotogram revealed a markedly shortened half-relaxation time of the ankle jerk. A moderate lymphocytosis of 57 per cent was noted with a total white count of 5,390.

The diagnosis of hyperthyroidism due to diffuse hyperplasia of the thyroid gland was made, and the administration of propylthiouracil, 100 milligrams every eight hours, was started. During the first six weeks of propylthiouracil therapy, the patient gained weight and was less hyperirritable. She then abruptly developed tenderness and swelling of her left ankle and right elbow, accompanied by a severe sore throat. On the next morning she was brought to the emergency room because of severe dyspnea, dependent edema, chest pain, and marked apprehension. She was admitted to the hospital when a marked increase in the heart shadow was noted in the chest roentgenogram (Figure 1).

On physical examination, the blood pressure was 130/100 mm. Hg; the pulse rate was 140, and the respiratory rate, 32 per minute. Her temperature was 103°F. The thyroid gland was unchanged in size and character; the pharynx was diffusely reddened. The heart was enlarged to percussion, the rhythm was regular, and a loud to and fro friction rub was present. Bilateral basal rales were present on auscultation of the lung fields. The liver was enlarged, and the lower extremities were edematous to the knees. The left ankle was tender and the right

* *Associate professor of medicine, University of Louisville School of Medicine.*

** *Associate professor of medicine and associate in psychiatry, University of Louisville School of Medicine.*



A. B. C.

Posteroanterior roentgenograms of the chest taken at standard distance of 6 feet. Normal cardiac silhouette prior to treatment, December 26, 1962. B. Pericarditis with effusion during propylthiouracil therapy, March 18, 1963. C. Return of cardiac silhouette to near normal at present time.

Figure 1.

elbow was swollen with some limitation of motion.

The admission laboratory studies revealed the following determinations to be within the range of normal: lupus erythematosus (2 times) and sickle cell preparations, latex fixation test, heterophile test, Coombs test, serum electrolytes and urea nitrogen, and urinalysis. The protein bound iodine was 7.5 micrograms per 100 ml. Both the C-reactive protein and the antistreptolysin determinations were abnormally elevated. The white blood count was 7,250 with 42 per cent lymphocytes.

Treatment with large doses of aspirin was continued for one week without evident improvement. During this time, three blood cultures and two more lupus preparations were reported as normal. The electrocardiogram demonstrated only sinus tachycardia. Prednisolone, 20 milligrams daily, was substituted for the aspirin, and the propylthiouracil was continued. Within four days, the patient showed marked improvement; her temperature was normal, and the cardiac friction rub was no longer present. Repeat auscultation of the heart did not detect any murmur. The chest roentgenogram was essentially normal. After three weeks of therapy, the prednisolone was stopped and the patient was considered ready for discharge from the hospital.

Two days later, the patient was again acutely ill with the original symptoms of severe dyspnea, chest pain, fever and dependent edema. The chest x-ray once again demonstrated pleural and pericardial effusions. Steroid administration for one week resulted in symptomatic improvement. Methimazole was then substituted for the propylthiouracil. For the next two weeks, the treatment consisted of prednisolone and methimazole, and the patient remained symptom-free. The steroid was then stopped, and the patient remained in the hospital for an additional month. She was then discharged and advised to continue methimazole, 30 milligrams daily, for the control of her hyperthyroidism.

Comment

This patient presented a complex diagnostic problem. It is clear that her initial illness was thyrotoxicosis which responded for a short time to the administration of propylthiouracil. A severe hypersensitivity syndrome characterized by fever, pleuritis, pericarditis, arthritis, and edema followed six weeks of propylthiouracil therapy. These symptoms responded to steroid therapy but immediately returned when the prednisolone was stopped. Readministration of the steroid followed by substitution of methimazole for the propylthiouracil resulted in prompt improvement in the hypersensitivity state. The patient now no longer requires prednisolone and has continued to tolerate the methimazole for the past three months.

In addition to drug hypersensitivity reaction, two other diseases were initially considered in this patient. Acute rheumatic fever is very unlikely in view of the lack of leukocytosis and heart murmur, especially since the patient was 17 years old at the time of the initial episode. Disseminated lupus erythematosus is more difficult to exclude, but is unlikely in the light of the four negative lupus erythematosus preparations, the absence of skin eruptions, the normal renal status, and the favorable clinical course.

The incidence of reactions to the commonly used antithyroid drugs is about the same re-

gardless of the particular drug used; it is important to note however that a patient may be tolerant to one of these drugs and intolerant to another.[1] Minor side effects such as dermatitis and fever are present in about 10 per cent of treated patients during the first few weeks of drug administration and disappear even though the drug is continued. Agranulocytosis is seen in about 1 per cent of treated patients and, while serious, is usually not fatal. Aplastic anemia is rare but almost always fatal.[2]

Hypersensitivity states have been reported to follow the use of propylthiouracil. McCormick described fatal polyarteritis following the readministration of the drug to a sensitive patient.[3] In 1952, Wing and Asper reported a young female who after 27 months of propylthiouracil administration developed fever, leukopenia, pleuritis, pericarditis, arthritis and hyperglobulinemia.[4] In 1963, Walzer and Einbinder reported immunoleukopenia as an aspect of hypersensitivity to propylthiouracil.[5]

It is interesting that the patient reported here has been able to tolerate without incident the use of methimazole for the treatment of the thyrotoxicosis. If drug sensitivity develops, or if the hyperthyroid state cannot be controlled with methimazole, it is planned to abandon the use of antithyroid drugs and treat the patient with radioiodine.

References

1. Williams, R. H., and Bakke, J. L. The Thyroid. In *Textbook of Endocrinology*, R. H. Williams, ed. Philadelphia, W. B. Saunders Company, 1962.
2. Trotter, W. R. The relative toxicity of antithyroid drugs. J. New Drugs, *2:* 333, 1962.
3. McCormick, R. V. Periarteritis occurring during propylthiouracil therapy. J.A.M.A., *144:* 1453, 1950.
4. Wing, E. S., Jr., and Asper, S. P., Jr. Propylthiouracil in hyperthyroidism. Bull. Johns Hopkins Hosp., *90:* 201, 1952.
5. Walzer, R. A., and Einbinder, J. Immunoleukopenia as an aspect of hypersensitivity to propylthiouracil. J.A.M.A., *184:* 743, 1963.

Make Arrangements Now

To Attend the

1964 Interim Meeting

of the

Kentucky State Medical Association

April 23 **Prestonsburg, Ky.**



Medicine's New Dimension

DURING the first week in December the Kentucky Medical Association Legislative Council met at the headquarters office in Louisville. All members were there and in addition our legal counsel came from Frankfort. Mr. Bobbie Grogan, Director of Field Services, attended, and there were seven invited guests who were not physicians. These guests were asked to present various aspects of proposed legislation which vitally affect our profession as well as their own fields of activity.

The meeting began with dinner at 6:30 and continued until 11 P.M. During this time all known major proposals for legislation affecting the medical profession which may be presented to the January session were discussed. There was a free exchange of opinion as to how best to approach these problems relative to health.

There is proposed legislation bearing on licensure of physicians, especially interns and residents in our hospitals, and of foreign graduates. The nursing profession is interested in regulations that might well affect hospital operations. Clarification of standards covering the distribution of milk and other foods; basic science examination requisite for medical license; laws to better define indigent medical care—these and a multitude of other proposals affecting our daily and professional lives are before us.

We have a legislative council who promise to keep us informed of proposed national and local issues. They will, during the next few months, be in and out of Frankfort in the interest of better health for Kentucky. Let's watch for their bulletins and, better still, let's respond when we as individuals are called upon for help. We do not need a powerful and expensive lobby in Frankfort but we as individual physicians need to be informed and willing to serve.

On the following day the KSMA Medical Advisory Committee of Blue Cross Hospital Plan in Kentucky met at the Blue Cross Building in Louisville. Fifteen men, one from each trustee district in the State, came together to better acquaint themselves with the operation of Blue Cross and to formulate an effective program of participation for physicians during the coming year.

Kentucky has a unique record among the 76 Blue Cross plans in the United States. From the beginning we as physicians have maintained a very active interest and a healthy participation in the policies and purposes in our Blue Cross; in a great number of states this has not been true. Furthermore we have been able to operate for seven years without a general rate increase to subscribers. Few plans have had so favorable an experience.

In an effort to prevent abuses of operation and to keep participating physicians informed and interested the Advisory Committee was formed and has recently been enlarged to embrace every trustee district in the state. Later Hospital Review Committees were established in an effort to keep locally at a minimum extravagant and unwarranted use of this insurance. Both projects have been effective.

These are only two of the activities of vital importance to our welfare and progress. There are many more to which just as much thought and effort are being directed. One of the encouraging signs of our time is that so many physicians are willing to devote their time and energy to the common good.

For fifteen years we have been warned by visiting physicians from England that we can escape regimentation of medical practice only by our intelligent, organized and persistent resistance; that we must propose effective and sound health plans and activate them if we are to prevent complete government control.

Ten years ago it would have been impossible to find so large as even our present low percent-

age of physicians alert and active in the field of legislation, public health, economic welfare and in indigent medical care. It is most encouraging that on two successive days twenty-five physicians scattered from Pikeville to Paducah and from Bellevue to Bowling Green are willing to come on their own time and at their own expense simply to promote better standards of medical care for our people. This is not exactly a new dimension in medicine but it is an encouraging trend. When every physician is willing to carry his share of such responsibility we will indeed be able to move forward.

SAM A. OVERSTREET, M.D.

Gobble-De-Gook!

SEVERAL years ago my secretary, now dead, warned me: "Doctor, you are getting to the age now when you may be trying to correct everybody. Watch it!"

In spite of this good advice, which I have thought of often and followed sometimes, the medical profession occasionally needs to be told: Don't use long words and involved sentences when short words and simplicity will do.

Often a long word, strange to the layman, is not only the right word to use but saves time and space. The word *metastasis,* for example, is clear to any doctor and takes the place of one or two pages of words necessary to make this clear to a layman. Wrapped up in this word is the whole meaning of cancer and its *ways* of spread (not *modalities,* please). This is technical language and absolutely necessary. It is not this I am complaining about (yes, I know the preposition is at the end of this sentence, and just where it belongs, too).

Why say *modality* instead of *way* or *mode; utilize* instead of *use; finalize* instead of *finish* or *end?*

What sparked this minor outburst was an expression I have just read in a good article in a medical journal, usually well edited. The author says".....was the first to delineate a conceptualization of ....," when all he means is ".....the first to show....."

Do you think the Gettysburg Address would sound better if Mr. Lincoln had ended with ".....that centralized federal administration of the population, for the population, and by the population should not finalize itself from the terrestrial globe?"

Would Mr. Churchill have been more impressive if he had said "I have nothing to offer except the fluid that circulates in the vascular channels of animals, unusual exertion, lacrimal fluid and the excretion of sudorific glands"?

Most things are better, certainly editorials, when they are short, clear, simple.

FRANCIS M. MASSIE, M.D.

Research Espionage

THE "Research Spy" who pilfers research data and secret knowledge is a new and dangerous threat to the security to American industrial research.

The implications of "Research Espionage" were told graphically in an address of Fred Bartenstein, Jr., administrative vice president of Merck & Company, drug manufacturers, to the National Seminar of the American Society for Industrial Security.

Millions of dollars are spent annually by the drug industry to develop the "wonder drugs" which save countless lives. The research process is not only costly but requires the expenditure of thousands of hours of work by skilled scientists. Security leaks and data thefts along the path of a company's investigations in developing one of these drugs are as much theft as actual stealing of the finished formula.

Mr. Bartenstein illustrated his talk with examples of such thievery from the experience of his own company. A spy in the company's

employ sold data documents to a master spy who, having bypassed the costly and lengthy research process, applied for patents and offered the compound to rival companies both in the United States and abroad.

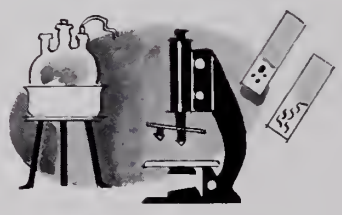
In another instance, a vistor to this country from another nation which refuses patents on drug invention was found to be a guest in the home of one of the company's employees. When the visitor left, security people sorted out from the employee's garbage the outside borders of a series of research memoranda and documents. The memoranda had gone with the spy to be put in shape for resale in the research espionage market.

Mr. Bartenstein related these two incidents from his company's own experience to the "Imponderable problems" this kind of theft imposes for all in the drug industry and medical profession.

He said: "The material of scientific communication is . . . an elusive commodity. Its usual vehicle—paper—is carryable, copyable and hidable. The knowledge itself, separate from its paper, is intangible. It cannot be seen, found, returned, or destroyed, and it can be used forever. Its theft is a subtle and sophisticated wrong."

After pointing out how present patent laws protect the innovator and his finished product, Mr. Bartenstein emphasized that these laws do not protect against the theft of secret knowledge and data. He urged that our present laws be so revised as to "reflect the reality that products of the mind have value as great as products of the hand."

If this protection is not provided, he said, "undeterred theft of these commodities weakens not only those scientists and those organizations who do the best work. It adds intolerably to the already large risk of research and it saps America at the very strategic point of its strength to withstand the onslaught of a massive economic attack."



March 16
Is the Date for the
Tenth Annual KSMA Senior Day at
the Medical Arts Building, Louisville.
All KSMA Members Invited.

SPECIAL ARTICLES

KSMA'S Statement on King-Anderson Bill as Presented Before House Ways and Means Committee*

GAITHEL L. SIMPSON, M.D.
Greenville, Ky.

THE Kentucky Kerr-Mills program has been criticized and misrepresented as being too limited in benefits, too rigid in its eligibility requirements and too inefficient in terms of administrative costs.

Eligibility Liberalized

Kentucky's MAA program was a modest one inaugurated on January 1, 1961. Since that time, however, it has been revised and expanded as experience and need have demonstrated the desirability to change. For example:

On January 1, 1961, the MAA program applied to persons with an annual income of $1,000 if single and $1,500 if married. Through progressive steps these limits are now $1,600 for single persons and $2,400 for couples.

Expansion of Benefits

Initially, our MAA program benefits were broad in scope but somewhat limited in extent. The physicians were paid for two home and office visits per month and the hospital was paid for three days of service. This however, did not mean that patients were summarily discharged from the hospital at the conclusion of three days stay. They continued to receive necessary hospitalization and medical care just as they have for past years. Physicians' visits to the hospital were not included in the coverage and only certain emergency care by dentists was allowed. Physicians, being taxpayers, agreed as an association that they would be willing to eliminate physicians' fees for in-hospital visits.

The program benefits in all categories have been expanded and today recipients are eligible to receive care for ten days per hospital admission without limitation on readmissions. Patients are entitled to eighteen physician home or office visits per year with an additional number by authorization.

Nursing homes which meet the "high criteria of attainment" requirements are eligible to participate on a reimbursement cost basis for 120 days per recipient per calendar year. An entirely new benefit has also been added. Medical Assistance to the Aged recipients who need "skilled" nursing home care are now eligible to receive benefits for an indefinite period, with all licensed nursing homes eligible to participate in this portion of the program on a flat rate basis.

Projected Expansion of Program

Payment for hospitalization will be increased from 10 to 14 days with an additional 7 days by authorization. Medical and dental coverage will be increased. Provision for "high criteria" nursing home care will be expanded to 180 days and home nursing visits will be added as an entirely new feature of the program.

With the expansion of hospital benefit period to ten days per admission, it is now estimated that the program covers 77% of the cost incurred by hospitals on program beneficiaries and pays for the total cost incurred by approximately 82% of those admitted under the program.

**This is the original of a statement from the Kentucky State Medical Association on H.R. 3920 (the King-Anderson Proposal) presented before the Ways and Means Committee of the House of Representatives on November 21, 1963, by Gaithel L. Simpson, M.D., Greenville, 1962 president of KSMA and current chairman of the Governor's Advisory Council for Medical Assistance.*

Administrative Costs

Finally, the question of "administrative costs" have been the object of some concern to those who choose not to believe in Kerr-Mills. These facts should again be examined. In the first three or four months of the program, administrative costs were approximately $1.24 for each dollar of benefits paid. It should be remembered, however, that the entire concept was new and it took a great deal of money to train staff, set up necessary mechanisms of administration and develop efficient methods of operation. It also took time to bring into the program those needing medical help. Today, the program's administrative costs are only 8% of the total, with a foreseeable lowering to 5%. It appears then that in the relatively short time that Kerr-Mills has been implemented in Kentucky, administrative costs have fallen from an initial 124% to 8.12% as of June 30, 1963. We believe that this answers the charge of excessive administrative costs and demonstrates the ability of Kentucky to care for those who need help in an economic and efficient manner.

More of the Kentucky Story

During the three years of the Kerr-Mills' existence in Kentucky, we have had an opportunity to observe its growth and we know it is providing an ever-increasing service to MAA recipients. Private insurance and voluntary efforts continue to grow and fill the needs of the people of our State.

On behalf of the physicians of Kentucky, therefore, I urge this Committee not to recommend the enactment of any legislation establishing additional federal medical programs.

Responsibility*

Mrs. J. Murray Kinsman

Louisville, Ky.

UNFORTUNATELY, in some sectors of present day society, the old-fashioned words "responsibility", "duty", "service", on which I was raised and on which, therefore, I have based my philosophy, are no longer held in good repute. I was brought up on the maxim, "If a thing is worth doing, it is worth doing well". I was astonished recently to be told by an outstanding citizen that this is poor reasoning, that many things are not worth much of one's efforts, that many things we do should be given only a small measure of our interest and ability. To me that is a negative viewpoint and one that creates the shoulder-shrugging attitude of those who say, "So what? What does it matter?"

It matters a great deal if we are to preserve our freedom. There are those who believe there is something of freedom in lack of responsibility, but we have only to look around us at the peoples who are not troubled by responsibility —the despotisms with which we have long been at odds. Only in a free society is one given a chance to choose or reject responsibility.

To many people the word "responsible" bears a connotation of fear or guilt and creates an attitude of burdensomeness. That is certainly one definition, but I prefer to think about constructive responsibility, implying reliability and trustworthiness.

The increase of wealth, population, and industry only add to the individual's responsibility and therefore to one's opportunity for service. It becomes the duty of all citizens to participate to the extent of their ability in answering the demands for volunteer service.

But what, you may ask, does all this have to do with the Auxiliary?

By tradition doctors are imbued with the idea of serving. They are interested in the humanitarian aspects of medicine. But as far back as 1911 doctors were being told that they should be as concerned with the pathology of society as with the pathology of disease.

In 1958, when Louis M. Orr, M.D., later president of the AMA, spoke to the senior students at the University of Louisville School of

* *This is a condensed version of the address given by Mrs. Kinsman at her inauguration as president of the Woman's Auxiliary to KSMA at the Annual Meeting of the Auxiliary held Sept. 24-26, 1963, in Lexington.*

Medicine, he explained that "today's concept of health has been broadened to include not just physical health, but mental well-being, coupled with a chance to live life fully in a good environment. Physicians today are spending many extra hours translating their knowledge into concrete means of creating better health and life for everyone".

Whether we realized it or not, when we married into the medical profession we automatically assumed some of our husband's responsibility for serving; and since by definition an auxiliary is "one that aids or helps; an assistant; a confederate" we are doubly enjoined to participate in bettering our communities.

If we are going to accept active participation and leadership in community affairs, we must first learn about community problems and community needs to be informed members in action. And when we extend the idea of serving to a broader scope of national and international health and well-being, we emphasize even more the necessity of being well-informed and knowledgeable about matters that concern us.

In the preface to "The Informed Heart", the author says, "No longer can we be satisfied with a life where the heart has its reasons which reason cannot know. Our hearts must know the world of reason, and reason must be guided by an informed heart".

Our "Bulletin" is a source of information for all of us and with our own Jo Rich joining the staff it promises to be even more readable and informative.

We shall continue to stress AMA-ERF, because costs of running medical schools increase all the time and this fund provides unrestricted grants for the schools. Through its Loan Guarantee Fund medical students are assured loans from banks to meet the cost of their education.

We are all obligated as responsible citizens to know the issues, the principles involved, and the character of the men and women who are seeking public office. Our civic obligations go hand in hand with the rights and privileges of citizenship. We must be alert to know and understand legislation affecting the medical profession.

This year "Operation Hometown" is the project of the Medical Association, carried on through each county society. Each county auxiliary has been asked to offer its help to its parent medical society. This is certainly a place where Members-At-Large can be helpful. Both the organized and unorganized groups are urged to assist the men in whatever way they can.

This year under the broad program for Community Service are grouped Civil Defense, Health Careers, International Health Activities, Mental Health, Rural Health, Safety, and Special Projects. The ancient Greek dramatists invented masks to portray moods or emotions, a synthetic device to create an impression on an audience. "By their works shall ye know them" seems a better way to create a good impression.

The Medical Self-Help Training Program is being stressed in Civil Defense as a means of coping with any disaster, be it natural or man-made.

We are asked to put "Recruitment for Health Careers" on our priority list and to become "Electioneers for Health Careers".

Through International Health Activities, auxiliaries provide supplies to bring medical relief to a world-wide community. As the Country Parson says, "Thoughtful folks always have helped needy neighbors—and still do, even though the neighbors now live thousands of miles from them". Used medical textbooks, sample drugs, medical supplies, instruments, bandage material—all are desperately needed.

"Project Hope" is endorsed by the Department of International Health of AMA. "Hope" began in the fall of 1958 when President Eisenhower asked a prominent Washington, D.C. heart specialist, William B. Walsh, M.D., to initiate a project aimed at international goodwill and understanding through personal contacts. Doctor Walsh submitted a plan for the world's first peacetime hospital ship, rechristened the S.S. Hope, and the establishment of the People-to-People Health Foundation, Inc., to carry out this important program of cooperation in the field of health. It is essential that five million dollars worth of Hope be raised to sustain the project's success and meet new challenges.

Nationally, the Committee on Mental Health is inaugurating a far-reaching program on "Suicide Prevention", a project that must be carried out, however, on the local level. Since suicide is the fourth major cause of death in men and the fifth in women, this program is a wonderful avenue of service to the community.

In safety, emphasis is currently being placed on gun safety. In cooperation with school of-

ficials, Boy Scouts, the Rifle Association and other groups, we are asked to urge training in correct gun handling for all youngsters who are allowed to handle guns. Somehow we should find a way to prevent the headlines we so frequently read about those children who are killed playing with 'unloaded' guns.

Rural Health embraces all these needs and provides a chance for cooperation with all the other Auxiliary committees.

But does all this mean that we must give up projects we are already working on, ideas from the past we want to try, suggestions from other groups about projects that need doing? No, indeed! We need continuity in our programs and projects, but we should also be interested in adopting new ideas if they meet a need in our community.

Does this mean that any one Auxiliary should try to do all the things suggested by National? Again, the answer is "No". Many suggestions are made, so that each group may decide what best fits its needs.

Of course the first and most necessary prerequisite for any program to be effective is an active membership. We need more members; we need more interested members. However, let me repeat: "No one person nor one committee can carry out a completely successful membership campaign. Each member, however, can contribute toward the total effort by acting as such an ambassador that she attracts others to our organization".

The words "respond", "responsive", and responsibility" all have the same derivation. I would like to add "correspond" to the group. Sometimes we feel as if we are sending out smoke signals when we write letters. We are frequently left wondering whether anyone saw the signal and interpreted it correctly.

The process of communication is simplicity itself. It consists of just four elements — the sender, the message, the channel through which the message is transmitted, and the receiver. There is no magic involved, but if the recipient of the message doesn't respond only magic would make it possible for the sender to know the answer.

My plea is that we all try harder than ever to communicate with one another. Many times a brief note on a post card will suffice. How much better off all of us would be to get a prompt "No" than to be left wondering whether the request will be granted.

My final plea is that you approach your Auxiliary work with zest, imagination, enthusiasm, always with a positive, constructive attitude and never forgetting that one of the objects of our organization is the cultivation of friendly relations among physicians' families.

April 23, 1964

is the date of

The KSMA Interim Meeting

Jenny Wiley State Park, Prestonsburg, Ky.

Mark Your Calendar Now!

in virtually all diarrheas... prompt symptomatic control

LOMOTIL®

TABLETS / LIQUID—Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Research in the Service of Medicine SEARLE

ORGANIZATION SECTION

Dr. Nyaradi Will Address KSMA At Interim Meeting April 23

"Free Enterprise or Disaster" will be the subject of one of the feature presentations during the 14th KSMA Interim Meeting April 23, 1964 at Jenny Wiley State Park by the former Hungarian Finance Minister, Nicholas Nyaradi, Ph.D.



"One of the best and most sought-after speakers on the national scene today, Doctor Nyaradi is currently serving as director of the School of International Studies at Bradley University," KSMA president George P. Archer, M.D., Prestonsburg, said. "We are most fortunate to obtain him, and are grateful to the American Medical Political Action Committee for making him available to us."

Born and educated in Hungary, Doctor Nyaradi, who is now an American citizen, received doctorates in political science and jurisprudence from the Royal Hungarian University of Budapest. Following World War II, he served first as Under-Secretary of the Treasury and then as Minister of Finance of Hungary until 1948, when increasing Soviet pressure forced him to leave the country with his wife.

Since coming to the United States, Doctor Nyaradi has become well known through his speeches and writings. His book, *My Ringside Seat in Moscow*, has been acclaimed as one of the best books ever published on Russia.

Doctor Archer also pointed out that the meeting is being held at a time when the redbud and dogwood are in bloom in the park, providing an attractive setting for the session. The new Mountain Parkway is now open from Winchester to Prestonsburg with the exception of nine miles, and an adequate number of rooms will be available for anyone attending.

The KSMA Board of Trustees will meet at the park on April 22, as will members of the Board of the Woman's Auxiliary.

Trimble County is First

The Trimble County Medical Society was the first county group to submit a full dues report for the 1964 calendar year. KSMA president George P. Archer, M.D., Prestonsburg, congratulated the Bedford group on its promptness and full cooperation.



George P. Archer, M.D., Prestonsburg, right, KSMA president, accepts on behalf of the Kentucky Educational Medical Political Action Committee an award from AMPAC for first place in ratio of KEMPAC membership to total state association membership. Presenting the award to Doctor Archer at the Portland AMA Clinical meeting in December is Donald Wood, M.D., Indianapolis, chairman of the Board of Directors of AMPAC.

Membership Award Given KEMPAC in Portland

The Kentucky Educational Medical Political Action Committee received top honors at the annual breakfast sponsored by the American Medical Political Action Committee Tuesday, December 3, during the Portland meeting of the AMA.

KEMPAC received the award for having the largest ratio of "PAC" members per total KSMA membership than the association of any other state.

KSMA president George P. Archer, M.D., Prestonsburg, accepted the award on behalf of Hoyt D. Gardner, M.D., Louisville, chairman of the KEMPAC Board of Directors, who was unable to be present, from Donald Wood, M.D., Indianapolis, chairman of the AMPAC Board of Directors.

Practically all of the Kentucky Delegation was on hand for the breakfast.

Use Your Legislative Key Man

KSMA's Legislative Key Man System is the Association's communicating link with its members on state and national legislation. Each county society selected its county legislative key man. The key man receives all legislative communication; therefore he should keep the society members informed on legislative activities. KSMA's Council on Legislative Activities suggests each society give the legislative key man ample time on the program at a future meeting to discuss the Association's legislative key man system.

Kentucky Well Represented in AMA House of Delegates

The KSMA delegates to the American Medical Association House of Delegates at Portland, Ore., December 1-4 were: Wyatt Norvell, M.D., New Castle, senior delegate; J. Thomas Giannini, M.D., Louisville; and John C. Quertermous, M.D., Murray, who served as alternate for J. Vernon Pace, M.D., Paducah, who was unable to attend.

KSMA President Archer sat in on all meetings of the House of Delegates and other sessions held in connection with the Portland meeting.

Charles G. Bryant, M.D., Louisville, another alternate, attended the meeting. The Kentucky delegation caucused twice during the meeting. Doctor Norvell was a member of the Reference Committee on Legislation and Public Relations. While Doctor Pace could not serve due to his absence, he was appointed a member of the Credentials Committee.

Congress on Mental Health Set May 14 in Louisville

Frank M. Gaines, M.D., Louisville, Chairman of the KSMA Mental Health Committee, recently announced that Kentucky's first day-long Congress on Mental Health will be held Thursday, May 14, at the Kentucky Hotel, Louisville.

Focusing on Kentucky Planning in Mental health, the Congress will be held in cooperation with the Kentucky Psychiatric Association and the Kentucky Department of Mental Health.

All interested physicians should submit their names to the KSMA Headquarters Office for further information. You are also urged to submit a list of lay personnel in your community who might be interested in attending the Congress.

KSMA Members Now More Active in AMA Posts

In addition to KSMA's three delegates and three alternates, the Association is represented in ten positions in AMA committees, councils, and sections.

Robert C. Long, M.D., Louisville, is a member of the AMA Board of Trustees. William R. Willard, M.D., Lexington, is a member of the Committee on Medical Education and Hospitals, and serves also on the Committee on Osteopathy and Medicine.

W. Vinson Pierce, M.D., Fort Thomas, is one of three representatives of the AMA to the Joint Commission for the Promotion of Voluntary Non-Profit Prepayment Health Plans, in addition to serving on the AMA Committee on Insurance and Prepayment Plans.

William T. Rumage, M.D., Louisvile, is serving on the Committee on Disaster Medical Care, and Arthur H. Keeney, M.D., Louisville, is a member of the Committee on Medical Aspects of Automotive Safety.

Owen B. Murphy, M.D., Lexington, is a member of the Committee on the Medical Aspects of Sports. Doctor Murphy also addressed the Annual Athletic Injury Conference sponsored by the AMA at Portland on Saturday, November 30.

Currently serving (as of January 1) as delegates to the AMA House of Delegates are: Wyatt Norvell, M.D., New Castle, J. Thomas Giannini, M.D., Louisville, and John C. Quertermous, M.D., Murray. Alternate delegates are: Charles G. Bryant, M.D., Louisville, William W. Hall, M.D., Murray, and Charles C. Rutledge, M.D., Hazard.

KSMA members holding AMA positions, but not representing KSMA, are Carroll L. Witten, M.D., Louisville, delegate from the AMA section on General Practice to the House of Delegates; and Russell E. Teague, M.D., state commissioner of health, who is vice-chairman of the AMA section on Public Health.

"Hypertension" is Topic of January 23 Seminar

Three prominent guest speakers will be featured on the program of the Seminar on Hypertension to be held January 23 from 1:00 to 6:00 p.m. at St. Joseph Infirmary Auditorium in Louisville.

Various aspects of high blood pressure will be discussed by Robert L. McMillan, M.D., clinical professor of internal medicine at Bowman Grey School of Medicine at Winston-Salem, N.C.; H. Mitchell Perry, M.D., assistant professor of medicine and director of the Hypertension Division at the University of Washington, Seattle; and Louis Tobian, Jr., M.D., associate professor at the University of Minnesota School of Medicine, Minneapolis.

The following complete program of the seminar was released by Bernard I. Popham, M.D., program chairman:

1:00 p.m.—*Etiology of High Blood Pressure:* Louis Tobian, Jr., M.D.

2:00 p.m.—*Diagnosis of High Blood Pressure:* H. Mitchell Perry, M.D.

3:00 p.m.—*Treatment of High Blood Pressure:* Robert L. McMillan, M.D.

4-6:00 p.m.—Case presentations of Hypertension with discussion from audience and panel. Panel members: Doctors Tobian, Perry, and McMillan.

The seminar, which is being co-sponsored by St. Joseph Infirmary, The Kentucky Academy of General Practice, and the Wallace Pharmaceutical Company, is acceptable for five accredited hours by the AAGP. All Kentucky physicians are invited to attend.

FOR THOSE WHO PLAN AHEAD

The 1964 Interim Meeting of the Kentucky State Medical Association has been set for April 23, at Jenny Wiley State Park near Prestonsburg.

The American Medical Association 1964 Annual Meeting will be held in San Francisco June 22-26.

The KSMA Annual Meeting is scheduled for September 29 through October 1, 1964, in Louisville.

The 1964 Interim Meeting of the AMA will be held in Miami Beach November 29 through December 2.

AMA House Offers Aid to President — Authorizes Tobacco Study And Considers KSMA Resolutions

The House of Delegates of the American Medical Association, during the 17th Clinical Meeting in Portland, Oregon, voted to support President Lyndon B. Johnson in foregoing national unity, and offered the AMA's resources, council, and cooperation in matters of health, and directed letters of sympathy to Mrs. John F. Kennedy, the widow of the late president, and family.

The two resolutions authorized by the KSMA House of Delegates to be presented to the AMA were considered at the Portland session. The KSMA resolution calling for greater promotion of health careers was not accepted on the ground that the intent of the resolution was already being carried out.

The KSMA resolution urging that the AMA's Council on Medical Education and Hospitals seek to have medical civics taught in all medical schools was not approved because most medical schools have been instructed to institute such a course. However, the intent of the resolution was approved.

"The combined testimony of the American Medical Association, the state societies and our allies made a far greater impact on the members of the committee, friend and foe alike, than at any other time in the history of this long and bitter conflict," said Edward R. Annis, M.D., AMA president, in commenting on the hearings of the House Ways and Means Committee on the King Anderson Bill.

To Study Tobacco and Health

The House approved a Board of Trustees proposal that the American Medical Association Education and Research Foundation undertake a "comprehensive program of research on tobacco and health."

Agreeing that many gaps exist in knowledge about the relationship between smoking and health, the House declared that the study should be "devoted primarily to determining which significant human ailments may be caused or aggravated by smoking, how they may be caused, the particular element or elements in smoke that may be the causal or aggravating agent, and methods for the elimination of such agent."

The House agreed that the project should be financed by a substantial contribution from the American Medical Association and that contributions should be solicited from other sources—industry, foundations, voluntary health agencies and physicians. It was emphasized that contributions will be accepted only if they are given without restrictions.

Subsequent to the House action, the AMA Board of Trustees voted to contribute $500,000 to help finance the research program.

The House considered two proposals related to Negro physicians—a Board report on hospital staff privileges and a resolution concerning membership eligibility in state and county medical societies. The Board report was approved, but the resolution was not adopted.

In adopting the Board report, the House declared that "members of the medical staff of every hospital, where the admission of physicians to hospital staff privileges is subject to restrictive policies and practices based on race, be urged to study this question in the light of prevailing conditions with a view to taking such steps as they may elect to the end that all men and women professionally and ethically qualified shall be eligible for admission to hospital staff privileges on an equal basis, regardless of race."

AMA Constitution and Bylaws

The House approved comprehensive revisions and rearrangements of the Association's constitution and bylaws as submitted by the Council on Constitution and Bylaws. Among the changes are the following:

1. The Annual and Clinical "Sessions" have been renamed the Annual and Clinical "Conventions."
2. The word "constituent" has been changed to "state."
3. Two types of membership have been created, "Active" and "Special." Active Members are Regular or Service Members. Special Members are Associate, Affiliate and Honorary Members.
4. Affiliate Membership will be available to American physicians engaged in medical missionary and similar educational and philanthropic labors located in possessions of the United States.
5. The Board of Trustees has been given express authority to appoint committees.

The House retained present provisions concerning voting on amendments to the constitution but agreed that this matter might be considered by the Committee to Review the Organization of the AMA House of Delegates.

Voluntary Health Agencies

In approving a Board report on professional relationships with voluntary health agencies, the House declared that "the AMA maintain its policy of neither approving nor disapproving national voluntary health agencies." It also agreed "that the AMA, through its Committee on Voluntary Health Agencies, maintain its position of offering guidance on medical aspects of national voluntary health agency programs."

The House approved the "Principles for Medical Guidance to National Voluntary Health Agencies" which contain a new definition of a voluntary health agency, objectives of the Committee on Voluntary Health Agencies and a list of suggested mutual obligations between the AMA and the national voluntary health agencies.

In another action, the House also agreed with a recommendation that the Committee on Voluntary Health Agencies be given the status of a council in the AMA organizational structure.

The House adopted a policy statement pointing out that in recent years there has been a dramatic growth of blood banking facilities in the United States and declaring that "it is highly essential that the organization of new blood banking programs and the modification of existing ones should have, in the interest of public health and safety, the approval of the county

or district medical society and, therefore, should be coordinated with existing approved blood banking facilities." The House also approved a floor amendment stating that since a blood bank can well be considered a medical facility, the top authority in a blood bank should be a physician.

Miscellaneous Actions

In considering a wide variety of reports and resolutions, the House also:

Changed the name of the Council on Scientific Assembly to the *Council on Postgraduate Programs;*

Changed the name of the Council on Medical Education and Hospitals to the *Council on Medical Education;*

Expressed gratification that the work of the Committee on *Medicine and Religion* has received widespread acceptance and support from state and county medical societies, religious groups and other related organizations;

Received a report on the AMA Members *Retirement Plan* and urged physicians to act quickly if they are to exercise their rights under Public Law 87-792 during 1963;

Approved recommendations for criteria on medical examinations for *driver limitation* under certain specified conditions;

Urged that the term *"the aging"* be used instead of "the aged" in all statements by the medical profession regarding older persons; Approved the *"Guides for Medical Society Committees on Aging"* and recommended their wide distribution and use;

Earnestly recommended that the state medical societies explore the advantages of implementing *Kerr-Mills programs* in a manner which will permit the care of beneficiaries under voluntary health insurance programs;

Resolved that the AMA attempt to have removed from the *Kefauver-Harris Amendment* those provisions which authorize the U.S. Food and Drug Administration to determine the effectiveness of drugs;

Reaffirmed the Association's policy of opposing the inclusion of self-employed physicians under *Social Security;*

Agreed that a *short form medical record* may be used in cases of a minor nature and, in general, should apply to hospital stays of 48 hours or less;

Urged all AMA members to continue to support the *Woman's Auxiliary* so that it can be successful in increasing its membership, raising more revenue and broadening its range of activities.

Contributions and Tributes

Merck Sharp and Dohme pharmaceutical company made its third contribution of $100,000 to the student loan fund of the American Medical Association Education and Research Foundation. The AMA-ERF also received a total of almost $400,000 from physicians in three states for financial aid to medical schools. Dr. Annis was "commended and encouraged in his great work for private enterprise and free American medicine."

The following Kentucky physicians registered at the Portland meeting according to the records of the AMA:

George P. Archer, M.D., Prestonsburg
Charles G. Bryant, M.D., Louisville
Robert H. Cofield, M.D., Covington
J. Thomas Giannini, M.D., Louisville
Robert C. Long, M.D., Louisville
Owen B. Murphy, M.D., Lexington
Wyatt Norvell, M.D., New Castle
John C. Quertermous, M.D., Murray
Edward I. Rustin, M.D., Pikeville
William R. Willard, M.D., Lexington
Carroll L. Witten, M.D., Louisville

WANTED: Physician for Staff Position in medical department of chemicals company with approximately 4000 employees; liberal benefits; salary commensurate with experience and qualifications; State license required; age limit 65. Write to:

E. Q. Hull, M.D.
Medical Director
P. O. Box 8004
South Charleston 3, West Virginia

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost — to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospitol Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.



Baker's

VOL. 1 NO. 1 FORECAST: HAPPY MOTHERS AND BABIES

NEW 'UNDER
SOLVES DIAP

Trio of suspects identified...

Bacteria a Prime Culprit Organisms such as Bacillus ammoniagenes and Alcaligenes faecalis metabolize urine into chemical irritants. Proper laundering of diapers helps reduce number of organisms, but cannot completely eliminate bacterial growth.

Ammonia and Urea Implicated Ammonia produced by microorganisms is a major cause of skin irritation that leads to diaper rash.

The Moisture—Maceration—Infection Cycle Moisture from urine and feces, combined with diaper friction, results in damp, macerated skin—an ideal environment for bacterial proliferation. In the absence of energetic countermeasures, the moisture—maceration—infection cycle continues, leads to chronic diaper rash problems.



by News



BAKER LABORATORIES, INC.

VER' AGENT
RASH CASE!

Diapersil successful!

tericidal to Ammonia-itting Pathogens Dia-sil contains benzalko-m chloride, which is idly 'cidal' to organisms plicated in diaper rash. nzalkonium chloride a proven record of ef-tiveness and safety.

Continued 'Uripellent' Protection Silicones in Diapersil form a water-resistant coating which shields the skin from bacterial by-products and from maceration. Silicones have been found outstandingly effective in diaper rash, even when other types of therapy have failed.

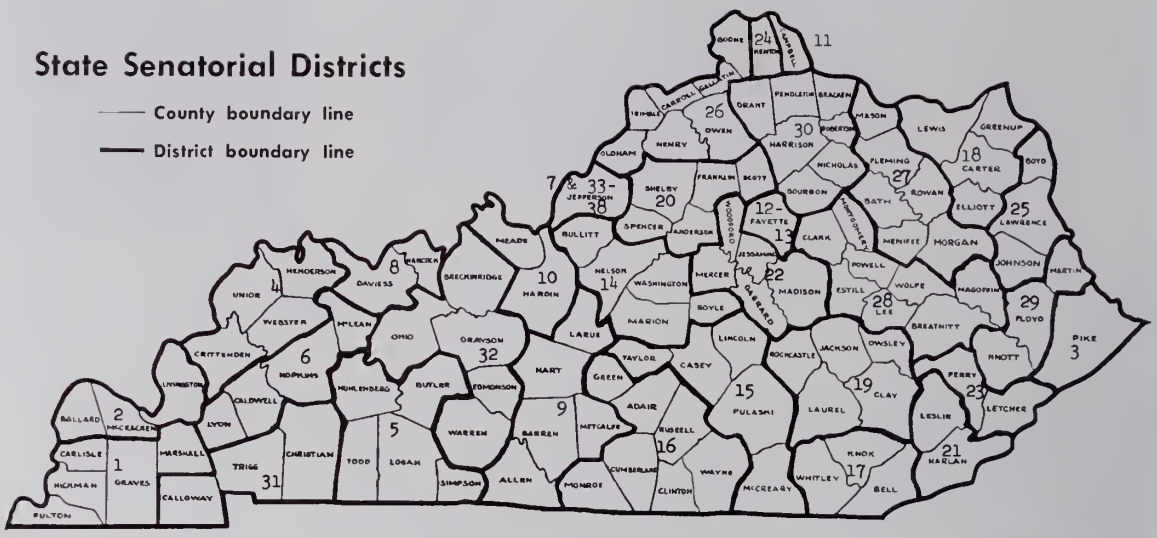
Soothing to Inflamed Skin Panthenol, incorporated in a soothing and non-sensitizing base, relieves itching and pain, and gently promotes healing. Diapersil thus provides prompt symptomatic relief in diaper rash as well as in other pediatric skin conditions.

AKER'S DIAPERSIL™ CREME

mula: panthenol, dimethylpolysiloxane, benzalkonium chloride, in a watermiscible, non-sensitizing cream base

To treat and prevent diaper rash, excoriated ttocks, chafing, heat rash and similar conditions

KER LABORATORIES, INC. Subsidiary of U.S. Vitamin & Pharmaceutical Corp.



Senators and Representatives Listed for 1964 Session

Democrats will continue to hold the edge in the 1964 Kentucky General Assembly both in the House and Senate. In the House, of 100 members 63 will be Democrats and 37 Republicans. There will be 51 new members. Of the 38 Senate members, there will be 25 Democrats and 13 Republicans. Of the total members, ten will be new.

In order to provide you with information concerning your 1964 legislators, The Journal is again printing a list of their names, addresses and districts, together with maps showing the counties they serve.

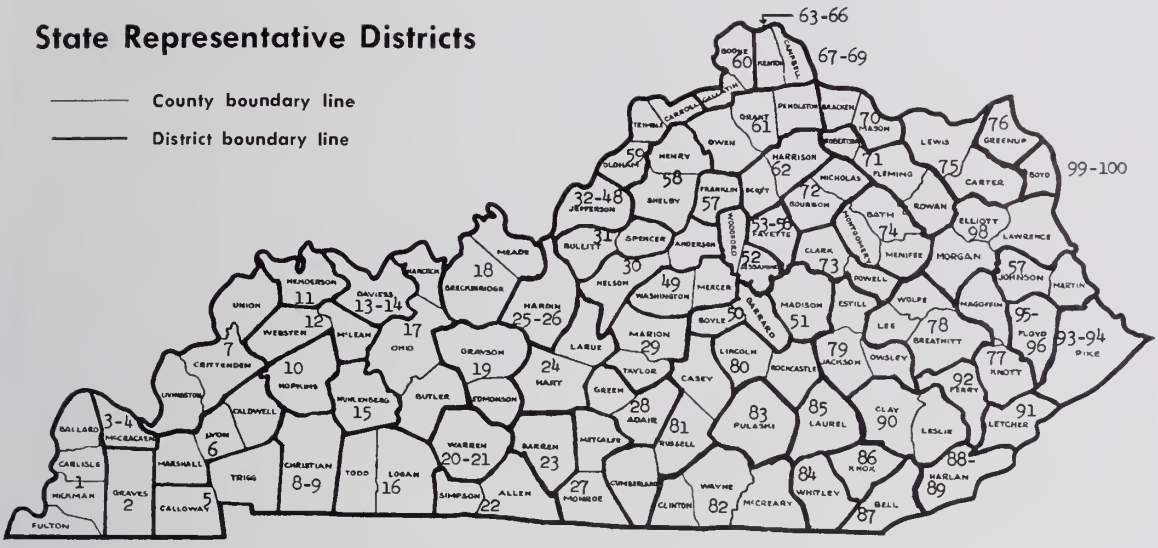
Kentucky General Assembly 1964 Members of Senate

District	Home County	Senators
1	Graves	George Brand (D), Mayfield
2	McCracken	Tom Garrett (D), Paducah
3	Pike	Foster Spence, D.M.D. (R), Pikeville
4	Webster	J. Murray Blue (D), Providence
5	Simpson	Thomas M. Brizendine (D), Franklin
6	Hopkins	Frederick E. Nichols (D), Madisonville
7	Jefferson	Robert P. Layne (R), Louisville
8	Daviess	Casper Gardner (D), Owensboro
9	Barren	James H. Newberry (D), Hiseville
*10		
11	Campbell	Donald L. Johnson (R), Ft. Thomas
*12	Fayette	
13	Fayette	Shelby C. Kinkead (D), Lexington
*14	Bullitt	J. D. (Jiggs) Buckman, Jr., (D), Shepherdsville
*14	Marion	Broadus E. Hickerson (D), Lebanon
15	McCreary	O. O. Duncan (R), Whitley City
16	Cumberland	Dr. William C. Mann (R), Marrowbone
17	Bell	Durham W. Howard (R), Pineville
18	Carter	Bert Kiser (D), Olive Hill
19	Clay	Pleaz Wm. Mobley (R), Manchester
20	Anderson	Marvin Edwards (D), Lawrenceburg
21	Leslie	Clay Gay (R), Sizerock
*22	Garrard	John W. Swope (R), Harrodsburg
*22	Jessamine	Mrs. Spencer Cobb (D), Nicholasville
23	Perry	William "Billy" Engle (D), Hazard
24	Kenton	James C. Ware (D), South Ft. Mitchell
25	Johnson	Wendell VanHoose (R), Tutor Key
26	Gallatin	Alvin Kidwell (D), Sparta
27	Fleming	Ed J. Kelly (D), Flemingsburg
*28	Breathitt	John Raymond Turner (D), Jackson
*28	Powell	Mrs. Herbert T. Derickson, Jr. (D). Stanton
29	Floyd	Fairis Johnson (D), Martin
30	Harrison	Wilson Palmer (D), Cynthiana
31	Calloway	Owen Billington (D), Murray
32	Breckinridge	Paul L. Fuqua (R), Hardinsburg
33	Jefferson	Bernard J. Bonn (D), Louisville
*34		
35	Jefferson	Martin J. Duffy, Jr. (D), Louisville
36	Jefferson	Scott Miller, Jr. (R), Louisville
37	Jefferson	C. W. A. McCann, (D), Louisville
38	Jefferson	Vernon C. McGinty (R), Louisville

**NOTE: Due to reapportionment some districts are shown with two senators while others are void. This situation will no longer exist after the 1965 General Election.*

Kentucky General Assembly 1964 Representatives

District	Home County	
1	Fulton	Henry Maddox (D), Hickman
2	Graves	Lon C. Barton (D), Mayfield
3	McCracken	Julian M. Carroll (D), West Paducah
4	McCracken	Fred Morgan (D), Paducah
5	Calloway	Charlie Lassiter (D), Murray



Note: Campbell and Kenton Counties should be indicated as separate districts on the above map. Johnson and Martin Counties comprise District 97, not 57.

6	Marshall	Shelby McCallum (D), Benton
7	Livingston	Everett E. Cook (D), Burna
8	Christian	John O. Hardin, III, (D), Hopkinsville
9	Christian	James Edmond Bruce (D), Hopkinsville
10	Hopkins	Richard L. Frymire (D), Madisonville
11	Henderson	Lewis N. Johnson (D), Henderson
12	Webster	Milton Ashby (D), Sebree
13	Daviess	Mrs. Louise Gasser Kirtley (D), Owensboro
14	Daviess	R. E. Hale (D), Owensboro
15	Muhlenberg	Fred Wallace, Jr. (R), Central City
16	Logan	Paul E. Young (D), Allensville
17	Ohio	Wayland Render (R), Centertown
18	Meade	C. H. Pile (D), Guston
19	Grayson	John W. Head (R), Leitchfield
20	Warren	A. E. "Doc" Tucker (D), Bowling Green
21	Warren	Edward G. Brown (D), Bowling Green
22	Allen	Raymond H. Barber (D), Scottsville
23	Barren	Paul Allen (D), Glasgow
24	Larue	James E. "Jim" Bondurant (D), Hodgenville
25	Hardin	Sam H. Watkins (D), Elizabethtown
26	Hardin	Martin Louis Straney (D), Radcliff
27	Monroe	Earl Carter (R), Tompkinsville
28	Adair	T. M. (Buck) Watson (R), Knifley
29	Marion	James E. Whitlock (D), Lebanon
30	Nelson	Sam Houtchens (D), Bloomfield
31	Spencer	Stuart S. Kelly (D), Taylorsville
32	Jefferson	E. Bruce Blythe, Jr. (R), Louisville
33	Jefferson	Allen E. Russell (R), Louisville
34	Jefferson	Louis E. Ballenger (R), Louisville
35	Jefferson	Martin W. Palmer (D), Louisville
36	Jefferson	Clarence R. Miller (D), Louisville
37	Jefferson	Fallis V. Buky (R), Louisville
38	Jefferson	Dexter S. Wright (R), Louisville
39	Jefferson	John W. Farmer (D), Louisville
40	Jefferson	Arthur Lloyd Johnson (D), Louisville
41	Jefferson	Charles (Mickey) O'Brien (D), Louisville
42	Jefferson	J. E. Smith (D), Louisville
43	Jefferson	Norbert L. Blume (D), Louisville
44	Jefferson	Charles J. Jones (R), Louisville
45	Jefferson	Jesse O. (Oz) Johnson (R), Louisville
46	Jefferson	Walter S. Reichert (R), Louisville
47	Jefferson	James M. Caldwell (R), Louisville
48	Jefferson	Eugene P. Stuart (R), Louisville
49	Washington	John M. Smothers (D), Springfield
50	Boyle	Howard P. Hunt, Jr. (D), Danville
51	Madison	Willie W. Green (D), Richmond
52	Woodford	Hill Maury (R), Versailles
53	Fayette	R. P. "Dick" Maloney (D), Lexington
54	Fayette	Joe E. Johnson, III. (R), Lexington
55	Fayette	Don Ball (R), Lexington
56	Fayette	John W. Morgan (R), Lexington
57	Franklin	Ralph Bates (D), Frankfort
58	Henry	Louis T. Peniston (D), New Castle
59	Oldham	Otis R. Chaudoin (D), Pewee Valley
60	Gallatin	T. Herbert Tinsley (D), Warsaw
61	Grant	Franklin Webster (D), Williamstown
62	Harrison	John Swinford (D), Cynthiana
63	Kenton	Kenneth F. Harper (R), South Ft. Mitchell
64	Kenton	Vernor O. Cottengim (D), Covington
65	Kenton	John J. Isler (D), Covington

Continued on page 66

66	Kenton	Gus Sheehan (D), Newport
67	Campbell	James E. Murphy (D), Newport
68	Campbell	Carl A. Bamburger (R), Bellevue
69	Campbell	Arthur L. Schmidt (R), Cold Spring
70	Mason	Mitchel B. Denham, M.D. (D), Maysville
71	Rowan	Allie W. Young (D), Morehead
72	Bourbon	Brooks Hinkle (D), Paris
73	Powell	B. E. (Nig) Billings (D), Stanton
74	Montgomery	Nell Guy McNamara (D), Mt. Sterling
75	Lewis	Wayne "Zeke" Secrest (R), Vanceburg
76	Greenup	L. H. "Pete" Nicholls (D), Greenup
77	Knott	Lawrence Watts (D), Pinetop
78	Breathitt	Russell Reynolds (D), Jackson
79	Jackson	John F. Marcum (R), Sand Gap
80	Lincoln	William Harold DeMarcus (R), Stanford
81	Cumberland	Claude R. Willen (R), Burkesville
82	McCreary	Archie Brown (R), Stearns
83	Pulaski	Leonard Hislope (R), Somerset
84	Whitley	Will K. Peace (R), Williamsburg
85	Laurel	Dexter McCowan (R), Mershons
86	Knox	H. L. Taylor (R), Barbourville
87	Bell	Harry M. Hoe (R), Middlesboro
88	Harlan	Lawrence Lankford (D), Cawood
89	Harlan	Vic Howard (R), Cumberland
90	Clay	John E. White (R), Manchester
91	Letcher	W. R. "Bill" Jordan (D), Jenkins
92	Perry	Alex McIntyre, Jr. (R), Hazard
93	Pike	Roy Sanders, M.D. (D), Dorton
94	Pike	Gether Irick (D), Stone
95	Floyd	W. J. "Bill" Reynolds, Jr. (D). Allen
96	Floyd	Fred Gearheart (D), Harold
97	Martin	Albert Dempsey (R), Inez
98	Elliott	Lynn B. Wells (D), Sandy Hook
99	Boyd	Thomas E. Chapman (D), Rush
100	Boyd	Charles D. Wheeler (R), Ashland

Industrial Physicians to Meet

The Kentucky Industrial Medical Association will hold its annual meeting on April 2, 1964, at the Holiday Inn North East, in Louisville. The meeting will begin at 2:00 p.m., followed by a social hour at 5:00 p.m. and dinner at six.

Police Get Injury Seminar

The KSMA, and other organized medical groups, the American Red Cross, and the Louisville Automobile Club cooperated to sponsor a one-day seminar on the treatment and transportation of injured persons for the Jefferson County Police at the University of Louisville December 17.

Expert medical advice was given to police about problems that could confront them in the line of duty. Eight physicians on the staff of the U. of L. Medical School participated. William T. Rumage, M.D., assistant clinical professor of surgery, acted as coordinator of the program.



Donald K. Dudderar, M.D., Newport, right, new president of the Campbell-Kenton County Medical Society, is pictured receiving the gavel of office from outgoing president Wilbur R. Houston, M.D., Erlanger. Doctor Dudderar was installed at the December meeting of the society.

Campbell-Kenton Society Elects

Don H. Frickman, M.D., Newport internist, was named president-elect of the Campbell-Kenton County Medical Society at its December dinner meeting held at the Town and Country Restaurant in Covington. In 1964 he will replace Donald K. Dudderar, M.D., Newport, who was installed as 1964 president at the same meeting.

Doctor Dudderar accepted the gavel from Wilbur R. Houston, M.D., Erlanger, outgoing president. A urologist, Doctor Dudderar received his M.D. from the University of Louisville in 1947. Both he and Doctor Houston have been active in KSMA council and committee work. Doctor Frickman is a 1949 graduate of the University of Cincinnati College of Medicine.

Medical School News

Medical School Appointments Announced by U. of L.

At its December 19 meeting the University of Louisville Board of Trustees approved the following faculty appointments at the School of Medicine:

Named clinical instructions in community health were Daniel Winebrenner, M.D., and Ferrel L. Clare, M.D. Daniel Walter Burke, M.D., and Gerald Berman, M.D., were appointed clinical instructors in ophthalmology, and C. Douglas LeNeave, M.D., and George M. Lawrence, M.D., were named clinical instructors in radiology.

Giovanni Raccuglia, M.D., associate professor of Medicine and chief of the section on hematology, was appointed an associate in pathology.



Accredited psychiatric hospital for private diagnosis and treatment

Approved by the Joint Commission of Accreditation of Hospitals.

Forty-acre estate to assure privacy in a restful environment.

Equipped to provide all modern and acceptable methods of treatment.

Ample classification facilities with qualified psychiatric nursing.

Full recreational therapy facilities.

CHARLES W. MOCKBEE, M.D.
Acting Medical Director

ISABELLE DAULTON, R.N.
Director of Nursing

GRACE SPINDLER, R.N.
Associate Director of Nursing

ELLIOTT OTTE
President and Chairman

CHARLES M. CLIFFE
Business Administrator

Brochure and rate schedule available on request

THE *Emerson A. North Hospital* INC.

(Founded 1874)

5642 HAMILTON AVENUE, CINCINNATI 24, OHIO • Telephones: 541-0135, 541-0136

News Items

Loyal K. Wilson, M.D., Harlan, has joined the Daniel Boone Clinic in that city, where he will limit his practice to orthopedics. A 1939 graduate of the University of Pittsburgh College of Medicine, Doctor Wilson interned at the Allegheny General Hospital in Pittsburgh. He completed his residency at the Children's Rehabilitation Institute in Baltimore. Doctor Wilson previously practiced in Waco, Texas.

Marthe Mary Saint Pierre, M.D., has joined the staff of the University of Louisville School of Medicine as a clinical instructor in Anesthesiology. A 1954 graduate of the Woman's Medical College of Pennsylvania, Doctor Saint Pierre interned at the "Hotel Dieu" in New Orleans, and was a resident at Charity Hospital in New Orleans and Children's Hospital in Philadelphia. She is a native of Windsor, Ontario, Canada.

Herbert Hudnut, M.D., has become associated with **Warren Proudfoot, M.D.**, at Morehead for the practice of internal medicine. A 1957 graduate of Harvard Medical School, Doctor Hudnut interned at Mary Imogene Bassett Hospital and was a resident there from 1958-59. His residency was completed at Peter Bent Brigham Hospital in 1963. Doctor Hudnut is a native of Cleveland, Ohio.

Daniel W. Burke, M.D., has become associated with **N. H. Burkhead, M.D.**, in Louisville, for the practice of opthalmology. A 1957 graduate of the University of Louisville School of Medicine, Doctor Burke interned at St. Joseph Infirmary before becoming a resident in ophthalmology at the Mayo Foundation, Rochester, Minn.

Harry J. Batts, Jr., M.D. has joined **W. L. Boswell, M.D.**, at St. Joseph Hospital in Lexington for the practice of radiology. Doctor Batts, who graduated in 1954 from the University of Louisville School of Medicine, interned at St. Joseph Infirmary in Louisville and was a resident at the University of Louisville affiliated hospitals. He was a general practitioner at Valley Station from 1955-60.

Nina Kateryniuk, M.D., psychiatrist, is now associated with the University of Louisville School of Medicine. Doctor Kateryniuk, a native of Kaluga, Russia, received her M.D. in 1949 from Karl Franzens University in Graz, Austria. She is serving as acting clinical director of the department of Psychiatry at Louisville General Hospital and at Norton Memorial Infirmary Psychiatric Clinic.

John W. McClellan, M.D., has joined the Henderson Clinic in Henderson for the general practice of medicine. A native of Harrodsburg, Doctor McClellan graduated in 1960 from the University of Louisville School of Medicine and interned at St. Elizabeth Hospital in Dayton, Ohio.

Forest F. Shely, M.D. has become associated with **Henry F. Chambers, M.D.**, at Campbellsville, for the general practice of medicine. A Lawrenceburg native, Doctor Shely graduated in 1949 from the University of Louisville School of Medicine. He interned at Good Samaritan Hospital before going to Louisa, Ky., where he practiced for 13 years.

Congratulations To The Journal
On Your 60th Anniversary

Wholesale Drugs
and
Physicians Supplies

JOHN T. VIE CO., INC.
WH 4-7784 New Albany, Ind.

Anesthesiology Residency
1 - 2 years
Cleveland Clinic — Available Now

Fully approved program available to graduates of approved medical schools who have completed an approved internship. Offers wide practical experience with all agents and methods including endotracheal intubation, spinal, regional and block anesthesia. Anesthesia for all surgical specialties including chest and open heart procedures, vascular surgery, and neurosurgery.

For further information write or call:

Dr. Donald E. Hale, Head of Dept. of Anesthesiology
or
Dr. Walter J. Zeiter, Director of Education
Cleveland Clinic Educational Foundation
2020 East 93rd Street, Cleveland 6, Ohio
Telephone: Area code 216, CE 1-6800

AMA Members Retirement Plan Discussed in November JAMA

If you have read the November 30 issue of the AMA Journal, you probably already know some details about the American Medical Association Members Retirement plan which is designed to meet the requirements of the "Self-Employed Individuals Tax Retirement Act of 1962" (Keough Law).

The prospectus in the November 30 Journal should help you decide how beneficial the plan would be to you. You are urged to study the Plan and discuss it with your financial advisor or attorney. If the Plan fits your individual circumstance, you will no doubt want to act ot once to secure the benefit.

For further information, enrollment guide, application forms, etc., write to the American Medical Association, P. O. Box 7092, Chicago, Illinois 60680.

Dr. Ling Named New Chairman Of Radiology at U. of L.

Ji-toong Ling, M.D., has been named new chairman of the department of Radiology at the University of Louisville School of Medicine, succeeding the late Everett L. Pirkey, M.D. Doctor Ling had been acting chairman of the department since February, 1963.

A native of Shanghai, China, Doctor Ling received his M.D. from St. John's University there in 1942. He came to the United States in 1948 and served on the staffs of several hospitals in this country before joining the faculty of the University of Cincinnati as instructor in Radiology. He came to U. of L. from Cincinnati in 1953.

Doctor Ling was certified by the American Board of Radiology in 1949. He is a member of the KSMA, the AMA, and the Jefferson County Medical Society, as well as a number of local and national specialty groups.

Dr. Haynes Named To Office

Douglas M. Haynes, M.D., professor and chairman of the department of Obstetrics and Gynecology at the University of Louisville School of Medicine, was named to serve a two-year term as secretary to the Section on Obstetrics and Gynecology of the Southern Medical Association during the 1963 meeting beginning the week of November 18.

Dr. Murphy on AMA Program

Owen B. Murphy, M.D., Lexington, presented a paper on "Supervised Seasonal Conditioning" before a scientific discussion group on The Preparation of the Athlete for Competition, during the AMA Interim Meeting in Portland early in December.

Doctor Murphy is a member of the KSMA School Health Committee.

CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of mental and nervous disorders, and addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director


Butazolidin®
Geigy
brand of
phenylbutazone
Tablets of 100 mg.
Proved by over a
decade of clinical
experience
It works!
Geigy
Pharmaceuticals
Division of
Geigy Chemical
Corporation
Ardsley, New York
Geigy

New KSMA Members Listed By Counties For 1962-1963 Associational Year

The following is the list of new members of the Kentucky State Medical Association who joined the KSMA between September 1962 and September 1963.

Adair
Reckmann, H. W.

Barren
Lewis, Albert G.
Oberlin, Donald L.
Pichardo, Paul A.

Bath
Cameron, Donald C.

Bell
Cullum, Albert G.
Young, Luther F.

Boone
Schworer, Philip B.

Bourbon
Hagan, John Campbell
Johnson, James E.

Boyd
Duff, W. R.
Harrison, J. W.
Komaso, B. P.
Reams, Gerald B.
Roth, Oliver
Williamson, James F.

Boyle
Reid, Sam H.

Breckinridge
Dew, Joseph
James, Carroll F.

Calloway
Hughes, D. G.

Campbell-Kenton
Jacobs, Alfred A.
Siles, James F.

Carroll
Ford, James

Christian
Kernohan, Wm. J.

Daviess
Gearhart, E. A.
Stiles, Joseph E.

Fayette
Aug, Robert G.
Ballard, Ted D.
Blue, Max E. Jr.,
Bosomworth, P. B.
Brest, Joyce
Brest, Stuart
Bryant, Lester R.
Burkhart, Wm. K.
Chamberlain, J. L. III
Fine, R. H.
Hyde, G. L.
Malek, John C.
Myers, John E. Jr.,
Orr, James A.
Pisacano, N. J.
Rackley, J. W.
Resinger, H. E.
Rush, B. F.
Sergent, R. L.
Shively, John A.
Surawicz, Borys
Tapp, Jesse W. Jr.,
Warren, J. E.,
Wells, Francis B.

Floyd
Martin, Lowell

Greenup
Collins, Adrion

Hardin
Guiglia, Theodore

Harlan
Hurlocker, J. K.

Henderson
Marchand, John H.

Hickman
Mills, Clarence

Hopkins
Coffman, S. E. Jr.,
Fitchett, Vernon H.
Jernigan, W. R.
Mogan, T. F.

Jefferson
Abrams, B. L.
Arik, Mehmet
Arnsparger, Ruby A.
Bashir, Abbas
Brill, J. E.
Brizel, Herbert
Brouner, I. E.
Campbell, T. E.
Carlberg, Dale
Collins, David
Collis, Stanley W.
Dickinson, Grady L.
Falkner, Frank T.
Flowers, Jeremiah
Frye, V. F. Jr.,
Goldberg, Lawrence
Goldsmith, M. L.
Green, Carl L.
Goddy, Leonard
Hamberg, Marcelle
Harbrecht, Phil
Hacker, Elmer B.
Howard, R. B.
Hulsman, P. J.
Kutz, Joseph
Ozlu, Cavit
Potts, Donald E.
Pesci, William
Roby, A. L.
Schoenbachler, E. B.
Scolzitte, Carmine J.
Stowens, Daniel
Vickers, Frank
Varga, Donald
Shipp, David
Weathers, Wm. G.
Wetzelberger, Craig
White, Robert K.
Williams, R. D.
Wolf, Richard S.
Young, Coleman H.

Laurel
Cherry, H. H.

Livingston
Burkhart, Stephen

McCracken
Rucker, R. H.

McLean
Hart, F. N.

Madison
Dick, Dover A.

Marion
Wilber, Robert H.

Mercer
Ballard, Ralph T.

Monroe
Marsh, John C.

Morgan
Bellamy, George R.

Muhlenberg
Brashear, James

Pike
Burian, Frank J.

Pulaski
Wilson, Thomas M.
Wyatt, William M.

Rowan
Caudill, Billie Jo

Shelby
Collins, Stephen F.

Taylor
Hogan, John

Webster
Logan, John A.

Woodford
Graul, William J.

A nine-month tutorial program in Cardiology will be offered by the Institute for Cardio-Pulmonary Diseases, Scripps Clinic and Research Foundation, LaJolla, Cal., from Sept. 15, 1964, to June 15, 1965. For details, contact E. Grey Dimond, M.D., Institute for Cardio-Pulmonary Diseases, Scripps Clinic and Research Foundation, LaJolla, Cal.

The 1964 Atlanta Graduate Medical Assembly will be held at the Atlanta Biltmore Hotel February 17-19. Included in the program are symposia on medicine, surgery, cardiology, obstetrics, gynecology and pediatrics, featuring outstanding guest speakers. For information contact Mrs. B. W. Shafer, Executive Secretary, Atlanta Graduate Medical Assembly, 875 W. Peachtree St., N.E., Atlanta 9, Ga.

"Diseases of the Newborn Infant" will be the theme of a postgraduate course sponsored by the department of pediatrics of the University of Cincinnati College of Medicine, to be held May 11-12 at The Children's Hospital in Cincinnati. In addition to lectures, the course will feature bedside clinical diagnosis and treatment. Registration will be limited to 50. Address all inquiries to A. M. Mauer, M.D., The Children's Hospital, Cincinnati 29, Ohio.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

In Kentucky

JANUARY

15	Cancer Teaching Lecture Series, University of Kentucky, Lexington, Ky.
16	University Surgery Day, University of Kentucky, Lexington, Ky.
16	Northern Kentucky Seminar, Kentucky Academy of General Practice, Cincinnati, Ohio.
23	Hypertension Seminar, St. Joseph Infirmary, Louisville, Ky.
24	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

FEBRUARY

6	Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.
13	Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.
13	Montly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
13-15	Rheumatic Diseases, University of Kentucky, Lexington, Ky.
19	Cancer Teaching Lecture Series, University of Kentucky, Lexington, Ky.
20	Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.
20	University Surgery Day, University of Kentucky, Lexington, Ky.
20	Contributions of Modern Pharmacology to Rational Clinic Use of Drugs, University of Kentucky, Lexington, Ky.
27	Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.
28	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

MARCH

5	Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.
12	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
12-14	Hematology, University of Kentucky, Lexington, Ky.
19	University Surgery Day, University of Kentucky, Lexington, Ky.
25-26	Kentucky Heart Association, Louisville, Ky.
27	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.
30-April 2	Kentucky Hospital Association, Louisville, Ky.

Surrounding States

JANUARY

13-17	Vaginal Endocrine Cytology. Ohio State University, Columbus, Ohio.
13-17	Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Miami Beach, Fla.
18-23	American Academy of Orthopaedic Surgeons, Chicago, Ill.
22-23	Dermatology, Indiana University, Indianapolis, Ind.
27-29	American College of Surgeons, Baltimore, Md.

FEBRUARY

5-6	General Practice, Cleveland Clinic Educational Foundation, Cleveland, Ohio.
5-8	American College of Radiology, Tucson, Ariz.
7-12	American Academy of Allergy, San Francisco, Calif.
12-16	American College of Cardiology, New Orleans, La.
20	Recent Advances in OB-GYN in General Practice, Ohio State University, Columbus, Ohio
26-27	Recent Advances in Pediatrics, Cleveland Clinic Educational Foundation, Cleveland, Ohio

Dr. Rouse, Speaker AMA House Made a Ky. Colonel

One of the highlights of the second session of the AMA House of Delegates during the AMA Interim Meeting at Portland, Ore., was the presentation of a Kentucky Colonelcy to the Speaker of the House, Milford O. Rouse, M.D., Dallas, Tex.

The presentation was made by John C. Quertermous, M.D., Murray, for the KSMA delegation.

Following the presentation, the House gave Doctor Rouse a standing ovation, and, at the suggestion of vice-speaker Walter C. Bornemeier, M.D., Chicago, the members of the House saluted the "new Colonel".

As we went to press, it was learned that Doctor Rouse had expressed his appreciation in a letter to the Kentucky delegation.

Dr. Bressler to Address KAGP

Bernard Bressler, M.D., professor of Psychiatry at Duke University School of Medicine, will present a "Discussion of Psycho-therapeutic Drugs" before the January 16 Northern Kentucky Seminar of the Kentucky Academy of General Practice to be held at the Sheraton-Gibson Hotel in Cincinnati.

R. E. Smith, M.D., Covington, program chairman, said that an interesting all-day program is planned, with registration to begin at 9:00 a.m. All Kentucky physicians are invited to attend the session, which is acceptable for five accredited hours by the American Academy of General Practice.

Heart Program Set March 25-26

The tenth annual Symposium on Cardiovascular Diseases, sponsored by the Kentucky Heart Association, will be held March 25 and 26 at the Brown Hotel in Louisville, according to information released by J. Herman Mahaffey, M.D., chairman, and R. L. McClendon, M.D., co-chairman.

A full program of the two-day session will be carried in a later issue of The Journal. All Kentucky physicians are invited to attend.

Treasurer's Report Omitted

When the full report of the 1963 KSMA House of Delegates Meeting was published in the December 1963 issue of The Journal, unfortunately a copy of the Treasurer's Report was inadvertantly omitted. Any member of KSMA wishing to see the report is asked to contact the Headquarters Office and a copy will be forwarded to him.

The Journal regrets this error.

Student Loan Bill Passed

A government loan program for medical students was recently passed by Congress. An article in the January 4 issue of the Journal of the AMA compares this program with the AMA-ERF Loan Program in regard to costs, coverage, and trends. It will also explain interest rates and the costs which go into securing and lending funds.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 2, 3, 4 and 5, 1964

Palmer House, Chicago

Lectures **Teaching Demonstrations**

Medical Color Telecasts **Film Lectures**

Instructional Courses

The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

cut Rx writing by 2/3 in colds, flu or grippe

NAME _____

ADDRESS _____

℞

No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct... economically sound... to specify

ANTITUSSIVE/DECONGESTANT/ANALGESIC
'EMPRAZIL-C'® TABLETS

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. **Caution:** While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. **Supplied:** Bottles of 100 tablets.

Also available without codeine as 'EMPRAZIL'® TABLETS

Complete literature available on request from Professional Services Dept. PML.



BURROUGHS WELLCOME & CO (U.S.A.) INC.

Tuckahoe, N. Y.

Continued from page 31

structors. Each county has been urged to participate in this program.

Of course, war is unthinkable to men of goodwill and sound mind. It would be a grave error to believe that the philosophy of other nations is identical with ours. We must remember that life and property, while valuable in America, are much less valuable in some other parts of the world. It is well to keep such things in mind before we grow overly optimistic about world peace.

Dr. Gilbert Named Regent

James T. Gilbert, Jr., M.D., Bowling Green, a member of the Graves-Gilbert Clinic, was recently elected to the Board of Regents of Western Kentucky State College at Bowling Green. Also currently serving a term on the Board of Regents is W. Gerald Edds, M.D., Calhoun.

Collection of Sample Drugs Sponsored by Ky. Jaycees

The KSMA Board of Trustees has asked that you be notified of "Project Concern," a program being sponsored by the Kentucky Junior Chamber of Commerce to collect sample drugs from doctors' offices during January for shipment to James Turpin, M.D., a missionary physician in Kowloon, Kong Kong, China.

Jaycee spokesman L. Jack Scott, M.D., Bowling Green, stated that in this area where drugs are scarce and the need is great, they hope this effort might help relieve some of the human suffering which becomes so commonplace in everyday life.

The drugs will be collected on a local basis by the Jaycees and shipped to Louisville as a central distribution point for Kentucky.

WANTED

GENERAL PRACTITIONER

AS FAMILY PHYSICIAN—To serve with quality Medical Group with Board Specialists, West Virginia College City of 30,000 near University Medical Center.

Starting salary $15,000-16,000; annual increments, excellent fringe benefits and opportunity

For information, call collect
Administrator, Area Code 304-366-0700

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venaus bleeding presents a problem. KOAGAMIN has an autstanding safety recard -- in 25 years of use no repart of an untaward reactian has been received; hawever, it shauld be used with care an patients with a predispositian ta thrambasis.



KOAGAMIN®

parenteral hemostat

Each cc cantains: 5 mg. axalic acid, 2.5 mg. malonic acid, phenal 0.25%; sadium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

Chatham CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey

Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

"They keep saying I'm sloppy!"



Nicozol® helps you restore your geriatric patients' interest in themselves

NICOZOL therapy can help you brighten the outlook of your aging patients who tend towards (1) untidiness, (2) irritability, (3) incompatibility, (4) lack of interest, and (5) loss of memory or alertness.

The NICOZOL formula helps improve mental acuity, increase the supply and use of oxygen in the brain, improve peripheral circulation—without excitation, depression, or other untoward effects.

NICOZOL can help you keep your aging patients actively alert and at ease with themselves, their families, and others.

Supplied: NICOZOL tablets (and capsules) in bottles of 100 and 1000. NICOZOL elixir in pints and gallons.

Precautions: May produce overstimulation in high doses. Discontinue if muscular twitchings or clonic convulsions occur. The flush produced in sensitive individuals is transient and harmless.

Average Dose: 1 to 2 tablets (or capsules) 3 times a day. 1 teaspoonful elixir 3 times a day.

Formula: Each tablet or capsule contains:
Pentylenetetrazol.....100 mg.
Nicotinic Acid.....50 mg.
Each teaspoonful (5 cc.) elixir contains:
Pentylenetetrazol.....200 mg.
Nicotinic Acid.....100 mg.
(as the sodium salt)
Alcohol.....5%

HART | Division of A. J. Parker Co. LABORATORIES Bryn Mawr, Pa., Winston-Salem, N.C.

NICOZOL®



"Upon arising, nose was open" . . . or how another happy patient describes the nasal decongestant action of Dimetapp Extentabs*—how would *your* patients describe it?/In Sinusitis, Colds, U.R.I., up to 10-12 hours' clear breathing on one tablet/Also available: Dimetapp Elixir, for t.i.d. or q.i.d. dosage..

Dimetapp® Extentabs®

[Dimetane® (brompheniramine maleate), 12.0 mg.; phenylpropanolamine hydrochloride, 15 mg.; phenylephrine hydrochloride, 15 mg.]

A. H. ROBINS CO., INC., RICHMOND 20, VA.

*CLINICAL REPORT ON FILE, MEDICAL DEPT., A.H. ROBINS CO., INC.

BRIEF SUMMARY: *Indications:* Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. *Side Effects:* In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. *Precautions:* Administer with caution in cardiac or peripheral vascular diseases and hypertension. *Contraindications:* Antihistamine sensitivity. Not recommended for use during pregnancy.

In Memoriam

JACOB WEBER, M.D.
Louisville
1865-1963

Jacob Weber, M.D., 98, retired Louisville general practitioner, died November 26 at a Louisville nursing home. A native of New Albany, Ind., Doctor Weber received his M.D. degree from the Medical Department of the University of Louisville in 1896, after graduating in 1888 from the old Louisville College of Pharmacy. An emeritus member of the Kentucky State Medical Association, Doctor Weber was a 50-year member of the Masonic Lodge, Kosair Temple, and Scottish Rite.

STEPHEN R. ELLIS, M.D.
Louisville
1911-1963

Stephen R. Ellis, M.D., 52, Louisville anesthesiologist, died December 1 at St. Joseph Infirmary in Louisville. A native of Ludlow, Ky., Doctor Ellis received his M.D. from the University of Louisville in 1938, and served in the Army Medical Corps in World War II with the rank of Colonel. A former president of the Kentucky Society of Anesthesiologists, Doctor Ellis was active in several other medical organizations.

HARRY G. STAMBAUGH, M.D.
Ashland
1890-1963

Harry G. Stambaugh, M.D., 73, Ashland, died November 30 at South Point, Ohio. An otolaryngologist, he had practiced medicine in Ashland since 1922. Doctor Stambaugh graduated in 1917 from the University of Tennessee College of Medicine in Memphis. He had been chief of staff of the former Stephenson Hospital in Ashland and was active in political affairs.

BEVERLY P. JONES, M.D.
Barbourville
1878-1963

Beverly P. Jones, M.D., 85, Knox County general practitioner for 57 years, died at the Knox County General Hospital in Barbourville on November 28. He was a 1906 graduate of the Medical Department of the University of Louisville. Doctor Jones was a member of the Knox County Board of Health and was a past member of the Selective Service local board. He was a former president of the local Kiwanis Club, a past member of the Chamber of Commerce and a past president of the Union National Bank of Barbourville.

IRA D. COSBY, M.D.
Henderson
1881-1963

Ira D. Cosby, M.D., 82, retired general practitioner, died November 9 after an illness of several months. Doctor Cosby, who graduated in 1903 from the Medical Department of the University of Louisville, had also practiced in Hebbardsville and Hawesville. He helped to organize the Henderson Hospital and served for many years on the staff of Deaconess Hospital in Evansville.

CASEY B. GRAVES, M.D.
Morganfield
1874-1963

Casey B. Graves, M.D., 89, died November 16 at Bethel Sanitarium in Evansville, Indiana, where he had been a patient for several months. A 1905 graduate of the Hospital College of Medicine in Louisville, Doctor Graves had been in general practice in Morganfield since 1906. Doctor Graves was for many years active in church, club and civic affairs in Union County.

EDGAR R. CLARK, M.D.
Louisville
1888-1963

Edgar R. Clark, M.D., 75, Louisville general practitioner for 54 years, died November 24 at Louisville General Hospital. A native of Johnson City, Tennessee, Doctor Clark graduated in 1911 from the Medical Department of the University of Louisville.

AUGUSTUS J. PAULI, M.D.
Louisville
1904-1963

Augustus J. Pauli, M.D., Louisville obstetrician and gynecologist, died suddenly of a heart attack on December 18 at St. Anthony Hospital, where he was chief of obstetrics. Doctor Pauli, 59, was a native of Little Rock, Arkansas, and graduated in 1931 from the University of Arkansas School of Medicine. He came to Louisville to practice in 1934. Doctor Pauli served in the Pacific Theater in World War II as a commander in the Navy Medical Corps.

Medical Paintings to be Shown

"A History of Medicine in Pictures" is the theme of a series of 42 original oil paintings by internationally-known artist Robert Thom, which will be shown at the University of Kentucky Medical Center from February 1 through February 28.

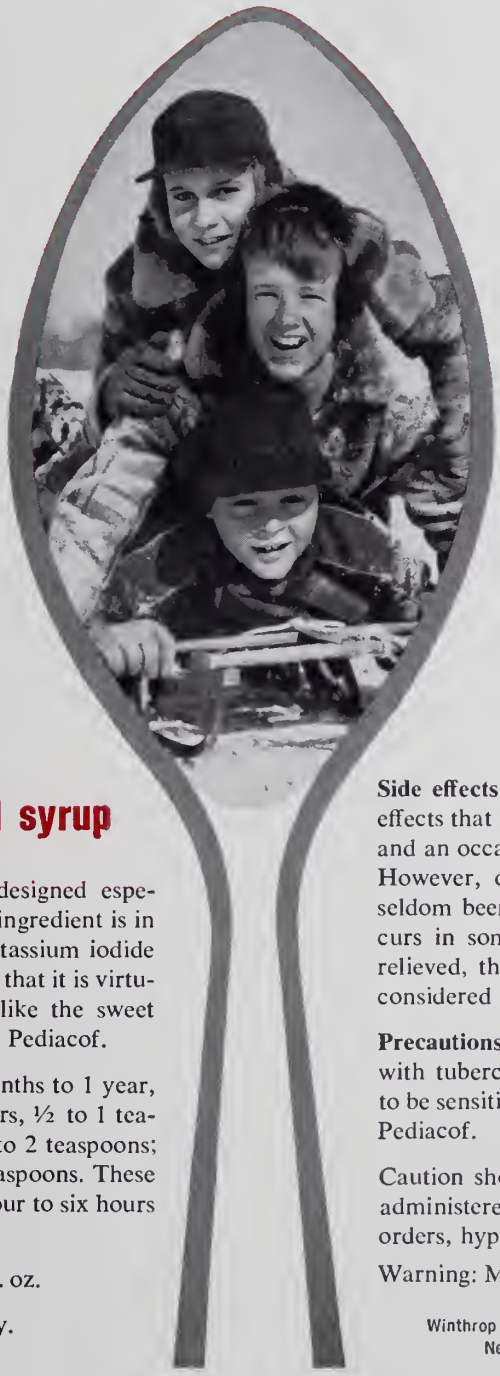
Among the paintings on display at the Medical Center will be: "Medicine in Ancient Egypt," "Primitive Medicine," "Medieval Hospitals," and "Harvey and the Circulation of Blood." The paintings were commissioned by Parke Davis Pharmaceutical Company.

Special cough formula for children

Pediacof®

Each teaspoon (5 ml.) contains codeine phosphate 5 mg., Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride) 2.5 mg., chlorpheniramine maleate 0.75 mg. and potassium iodide 75 mg.

soothing decongestant and expectorant



bright red, pleasant-tasting, raspberry-flavored syrup

Pediacof is different. It is designed especially for children, and each ingredient is in the right proportion. The potassium iodide in Pediacof is so well masked that it is virtually unnoticeable. Children like the sweet raspberry flavor of bright red Pediacof.

Dosage: Children from 6 months to 1 year, ¼ teaspoon; from 1 to 3 years, ½ to 1 teaspoon; from 3 to 6 years, 1 to 2 teaspoons; and from 6 to 12 years, 2 teaspoons. These doses are to be given every four to six hours as needed.

How supplied: Bottles of 16 fl. oz.

Available on prescription only.
Exempt Narcotic.

Side effects: The only significant untoward effects that have occurred are mild anorexia and an occasional tendency to constipation. However, discontinuance of Pediacof has seldom been required. Mild drowsiness occurs in some patients but, when cough is relieved, the quieting effect of Pediacof is considered beneficial in many instances.

Precautions and contraindications: Patients with tuberculosis or those who are known to be sensitive to iodides should not be given Pediacof.

Caution should be exercised if Pediacof is administered to patients with cardiac disorders, hypertension or hyperthyroidism.

Warning: May be habit forming.

Winthrop Laboratories
New York, N.Y.

Winthrop

1843M

100 Kentuckians Among Registrants At SMA Annual Meeting in New Orleans

One hundred Kentucky physicians registered for the Southern Medical Association's 57th Annual Meeting held November 18-21 in New Orleans. During the meeting Robert D. Moreton, M.D., Fort Worth, Tex., was installed as 1963-64 president of the Association.

Doctor Moreton, a radiologist, served as the Association's councilor from Texas from 1955-60, and has served as chairman of the Council, and as first vice president of SMA.

A number of Kentucky physicians participated in the various scientific programs which were a feature of the meeting. A list of Kentuckians taking part in the scientific sessions was carried in the November issue of The Journal.

The complete list of Kentuckians registered at the meeting follows.

C. W. Air, M.D.
Ludlow
Andres Alonso, M.D.
Harlan
Earl W. Atherton, M.D.
Clay
William H. Barnard, M.D.
Elizabethtown
James R. Barnes, M.D.
Louisville
Francis H. Bledsoe, M.D.
Lexington
Clyde M. Brassfield, M.D.
Elizabethtown
R. Rhodes Burnam, M.D.
Louisville
Boyd Caudill, M.D.
Lawrenceburg
James Childers, M.D.
Louisville
Ballard F. Combs, M.D.
Lexington
William H. Cox, M.D.
Paris
Thomas J. Crice, M.D.
Louisville
M. R. Cronen, M.D.
Louisville
Joseph F. Dougherty, M.D.
Florence
Henry F. DeLong, M. D.
Pleasure Ridge Park
Ralph M. Denham, M.D.
Louisville
E. E. Devillez, M.D.
Covington
O. T. Evans, M.D.
Lexington
W. R. Gobbert, M.D.
Owensboro
Hoyt D. Gardner. M.D.
Louisville
Isadore Goldstein, M.D.
Louisville
John D. Gordinier, M.D.
Louisville
G. Y. Graves, M.D.
Bowling Green
John W. Greene, Jr., M.D.
Lexington
Cecil L. Grumbles, M.D.
Louisville
E. O. Guerrant, M.D.
Winchester
George Gumbert, Jr., M.D.
Lexington
J. Duffy Hancock, M.D.
Louisville
Fred C. Hauck, M.D.
Owensboro
O. J. Hayes, M.D.
Louisville
Douglas M. Haynes, M.D.
Louisville
C. H. Heisel, M.D.
Covington
Lee C. Hess, M.D.
Florence
Donald G. Hughes, M.D.
Murray
V. A. Jackson, M.D.
Clinton
Charles B. Johnson, M.D.
Russell
Conrad H. Jones, M.D.
Murray
David L. Jones, M.D.
Fulton
Albert H. Joslin, M.D.
Owensboro
B. J. Kidd, M.D.
Brownsville
Harold L. King, M.D.
Benton
Thomas Kirby, M.D.
Bowling Green
Wayne Kotcamp, M.D.
Louisville
Ullin W. Leavell, M.D.
Lexington
David T. Lewis, M.D.
Elizabethtown
R. Lich, Jr., M.D.
Louisville
J. Keith Linville, M.D.
Louisville
Marvin A. Lucos, M.D.
Louisville
Roderick MacDonald, M.D.
Louisville
Paul F. Maddox, M.D.
Campton
Merle M. Mahr, M.D.
Madisonville
J. B. Marshall, M.D.
Louisville
T. R. Marshall, M.D.
Louisville
John Marsh, M.D.
Gamaliel
Dexter Meyer, Jr., M.D.
Covington
Joseph R. Miller, M.D.
Benton
Andrew M. Moore, M.D.
Lexington
R. C. Moss, M.D.
Bowling Green
Rudolph J. Muelling Jr., M.D.
Lexington
David H. Neustadt, M.D.
Louisville
Louis J. Nvtini, M.D.
Faranger
Mehmet H. Onder, M.D.
Harlan
Sam A. Overstreet, M.D.
Louisville
Irving B. Perlstein, M.D.
Louisville
W. Vinson Pierce, M.D.
Covington
Harold D. Priddle, M.D.
Paducah
B. F. Radmacher, M.D.
Louisville
Howard L. Ravenscraft, M.D.
Covington
Edward H. Ray, M.D.
Lexington
Robert L. Rice, M.D.
Richmond
J. S. Robbins, M.D.
Mayfield
Charles C. Rutledge, M.D.
Hazard
Otto H. Salsbery, M.D.
Covington
R. D. Sanders, M.D.
Louisville
George W. Schafer, M.D.
Williamsburg
Merrill W. Schell, M.D.
Owensboro
Wm. F. Schnitzker, M.D.
Ashland
E. P. Scott, M.D.
Louisville
Kenneth L. Sears. M.D.
Lexington
Jane B. Sears, M.D.
Lexington
George A. Sehlinger, M.D.
Louisville
Frank K. Sewell, M.D.
Mt. Sterling
Art J. Shulthise, M.D.
Louisville
H. Ted Smiser, M.S.
Cynthiana
Charles C. Smith, Jr., M.D.
Louisville
Donn L. Smith, M.D.
Louisville
Elmer R. Smith, M.D.
Somerset
Curtis . Songster, M.D.
Vine Grove
R. C. Tate, M.D.
Louisville
C. Dwight Townes, M.D.
Louisville
F. Norman Vickers, M.D.
Louisville
Claude C. Waldrop, M.D.
Wiliomstown
J. T. Walsh, M.D.
La Grange
Edward Warrick, M.D.
Louisville
Roy G. Wilson, M.D.
Campbellsville
Herman Wing, M.D.
Louisville
Thomas J. Wright, M.D.
Stanford

The 27th annual meeting of the New Orleans Graduate Medical Assembly will be held March 2-5 at the Roosevelt Hotel in New Orleans. Requests for information should be addressed to the New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, La., 70112. The course is acceptable for 29 accredited hours by the AAGP.

"General Practice" will be the subject of the February 5-6 postgraduate course offered by the Cleveland Clinic Educational Foundation, Cleveland, Ohio, and sponsored by the Cleveland chapter of the American Academy of General Practice. This course is acceptable for 10 accredited hours by the AAGP. For applications or information, contact Education Secretary, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Psychology Course in Progress

A 20-week postgraduate course in psychology for practicing physicians will be concluded January 30. The course, sponsored by the University of Louisville School of Medicine, is being held each Thursday at the Louisville Area Mental Health Center at Norton Memorial Infirmary from 2-6:00 p.m.

Applications for the remaining sessions should be made to Warren Cox, M.D., coordinator, or Presley Martin, M.D., program director, at the Louisville Area Mental Health Center, Norton Memorial Infirmary, 231 West Oak St., Louisville, Ky., 40203.

Evacuation and/or Shelters—Hackett

Continued from page 33

Local civil defense directors can provide medical planners additional and considerably more detailed shelter information for each county, standard location, and even for some individual buildings. County medical society Disaster Medical Care Committee chairmen should consult frequently with the local Civil Defense coordinator on this and other related problems.

Challenge and Response

We are now developing our first real capability to survive under nuclear attack. Progress has been made, but much remains to be done. The initiative, planning and the farsightedness must come from leadership and professional competence shared by the medical profession. Given this, the large majority of Americans will do what is necessary to contribute to the defensive strength of their country.

The fundamental lesson that can be drawn from our experience thus far with the new (FDA) clinical regulations is an old one: morals cannot be legislated. Most pharmaceutical firms are irked, of course, that they are now being compelled by law to document massively the steps they were taking before, quite voluntarily, based on good business practice and a feeling of public responsibility and pride in their products. The necessity for putting every detail on paper is both frustrating and time-consuming. Drug safety requires scientific judgment, which cannot be legislated. Most companies take far greater precautions than called for by the law, because their business sense and scientific judgment calls for such precautions. They know that if anything goes wrong, liability will rest with the drug manufacturer and not the Food and Drug Administration.—Austin Smith, M.D., to American Psychiatric Association, St. Louis, Mo., May 7, 1963.



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®
meprobamate 200 mg.+
pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

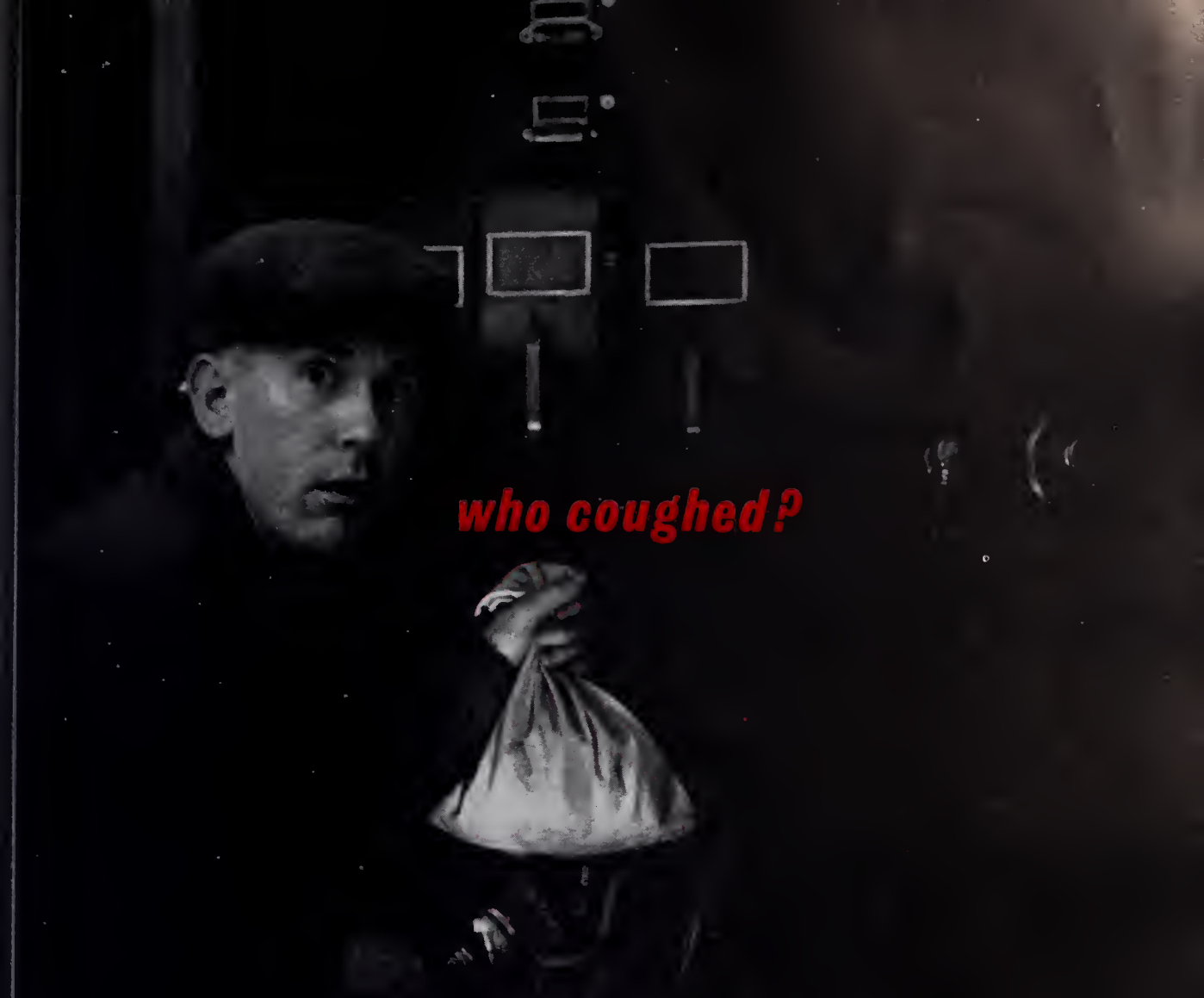
THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lossiter, Representative
203 Porkside Building, 4140 Shelbyville Road, Louisville 7
Mailing Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884



for fast and long-lasting cough control

HYCOMINE SYRUP

Each teaspoonful (5 cc.) contains:

Hycodan®	
Hydrocodone bitartrate . . 5 mg.	6.5 mg.
(Warning: May be habit-forming)	
Homatropine methylbromide 1.5 mg.	
Pyrilamine maleate	12.5 mg.
Phenylephrine hydrochloride	10 mg.
Ammonium chloride	60 mg.
Sodium citrate	85 mg.

in a highly palatable, cherry-flavored vehicle (methylparaben 0.13% and propylparaben 0.02% as preservatives)

INDICATIONS: For both productive and nonproductive cough. For relief of symptoms in tracheitis, bronchitis, pneumonia, pharyngitis, bronchial asthma, pertussis, and allied conditions; cough associated with allergy; in general, whenever cough medication is indicated.

DOSAGE: Average adult dose—1 teaspoonful after meals and at bedtime with food. Children 6 to 12 years, ½ teaspoonful; 3 to 6 years, ¼ teaspoonful; 1 to 3 years, 10 drops; 6 months to 1 year, 5 drops; after meals and at bedtime. On oral Rx where state laws permit. U. S. Pat. 2,630,400.

CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine HCl and in patients with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients use should not exceed three days. Hycomine Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur. May be habit-forming.

Endo

Literature on request

ENDO LABORATORIES Richmond Hill 18, New York

U.K. Gets Grant for Nursing

A total of $258,527 was recently awarded to the University of Kentucky in the form of a four-year grant for the development of semiprofessional nursing programs at four regional university centers. The grant is part of a $1,138,000 donation from the W. K. Kellogg Foundation of Battle Creek, Mich., toward the establishment of programs offering associate degrees in Nursing in Kentucky, Indiana, and Illinois.

The drug industry is facing a critical period concerning research required for new drugs. Many of these drugs will be important for the cure of diseases. The physician should have available modern discoveries even though there may be side effects in some of the drugs that are prescribed for specific purposes determined by the professional mind. The drug industry knows then they have discovered something beneficial for mankind. The thinking citizen of this country should not condone the "whipping-boy attitude." Politicians prey on people for votes. The pharmaceutical industry must stand on the merits of the products produced. Their voice should be strong and backed by other professions in the medical world to insure our medical progress. Let us be mindful of the axiom. "Divide and Conquer."—George X. Schwemlein, M.D., in *Cincinnati Journal of Medicine*, August 1963.

Most physicians have little knowledge of how drugs are evaluated and what constitutes standards of safety and criteria of efficacy. They do not know how drugs are tested and are not aware of the very considerable pitfalls of much of so-called "clinical pharmacology". Distribution of information on these matters by organized medicine to its own members now would, I believe, serve a very useful purpose. How valuable it would be to the practicing physician if he could learn something of the vagaries of clinical testing and drug evaluation. The standards of his own everyday practice would improve and he could begin to evaluate claims for new drugs with which he is beset. This process should begin in medical school, but we can hardly postpone approaching the generation of physicians who are already entrusted with patient care.—Thomas B. Turner, M.D., Dean, Johns Hopkins University School of Medicine, at Conference of Professional and Scientific Societies, Chicago, Ill., June 27, 1963.

The volume of proposed state legislation affecting drugs has almost quadrupled in the last ten years. In the first four months of 1963 the staff of the Pharmaceutical Manufacturers Association reviewed approximately 1,200 drug-related bills. Drug laws already on the books of our states number in the hundreds, and there are more than 190 state agencies, in the aggregate, which are administering statutes affecting drugs. Some P.M.A. member companies are now filing as many as 1,100 different reports with state governments in a single year.—Eugene N. Beesley, President, Eli Lilly and Company, to American Pharmaceutical Association, Miami Beach, Florida, May 13, 1963.

The

1964

KSMA Interim Meeting

will be held

April 23 at

Jenney Wiley State Park

Prestonsburg, Ky.

All KSMA Members are urged to attend this important meeting.

MURFREESBORO - VACANCIES: STAFF PHYSICIANS for 1275 bed neuropsychiatric hospital, including 350 general medical and geriatric. Modern facilities for diagnosis and treatment of mental illness. Salary $11,150 to $18,405 depending on qualifications; fringe benefits; cost of moving to Murfreesboro will be paid by Veterans Administration; visit here for evaluation can be arranged at our expense. Excellent educational opportunities for students in this area. Contact Director, Veterans Administration Hospital, Murfreesboro, Tenn.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient").*

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting. constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193

WASHINGTON NEWS DIGEST

WASHINGTON, D. C.—Both sides squared off for a new legislative battle this session of Congress on the issue of financing a medical-hospital plan for the aged through higher social security taxes.

There was no vote on the disputed King-Anderson bill (H.R. 3920) in Congress last year. The House Ways and Means Committee held five of a scheduled nine days of hearings on the bill in November, but broke the hearings off on news of the assassination of President Kennedy. The sessions were scheduled to be concluded in January.

The financial soundness of the administration's bill was challenged by Ways and Means Committee Chairman Wilbur Mills (D., Ark.). He told Administration witnesses that if Congress had approved similar legislation in the past, it apparently now would have to increase the Social Security tax almost 100 per cent to maintain the actuarial balance of the Social Security system.

Mills said the quarrel he has with the proposed increased tax in the bill is that it does not take into account future costs and the effect they would have on the fiscal soundness of the overall Social Security System. He said a bill should not give the impression that the aged can get these services at some cut-rate cost, or that the economy and costs will remain static.

"If that is a realistic assumption, then I do not know what an unreal assumption is," said Mills. If such a program is passed, he continued, Congress must face up to the costs and provide a tax in existing law that will take into account future costs.

If the King-Anderson bill were enacted with a shaky actuarial basis, Mills said, action by some future Congress would be necessary to raise the taxes to support it, and this might be very difficult.

Mills has introduced a bill to increase the regular Social Security tax and the wage base it is levied on so that the system will be financially in order.

HEW Secretary Anthony Celebrezze told the committee that congressional enactment of the Administration's plan for a hospital-medical benefit program financed by higher Social Security taxes is both "necessary and urgent."

Another major development at the hearings was an attack by Sen. Karl Mundt (R., S.D.) on HEW officials for trying to impede the Kerr-Mills program of federal-state aid for the indigent and medically-indigent elderly.

Mundt declared that Kerr-Mills is the victim of a planned program of interference on the part of the Department of HEW, King-Anderson supporters in Congress, and welfare workers and officials at the state and county levels. He suggested the HEW actions ran counter to the intent of Congress and might be illegal.

The president of the American Medical Association told the Committee that the Administration-backed health care for the aged plan would cost the nation's workers twice as much to start as sponsors of the proposal have claimed or would require periodic tax increases to keep it solvent.

Edward R. Annis, M.D., Miami, Fla., surgeon, pointed out that previous testimony disclosed that payroll taxes would have to be increased by one per cent, half paid by the workers and half by their employers, and the taxable wage base increased to $5,200 to start the program off on a financially sound basis, or periodic tax increases would be required to keep it out of financial trouble.

The King-Anderson bill (H.R. 3920) calls for a one-half per cent payroll tax increase on workers and employers (one-fourth of one per cent on each) and an increase in the taxable wage base from the present $4,800 to $5,200 to finance a proposed program of hospitalization, nursing home care and related services to everyone age 65 and over.

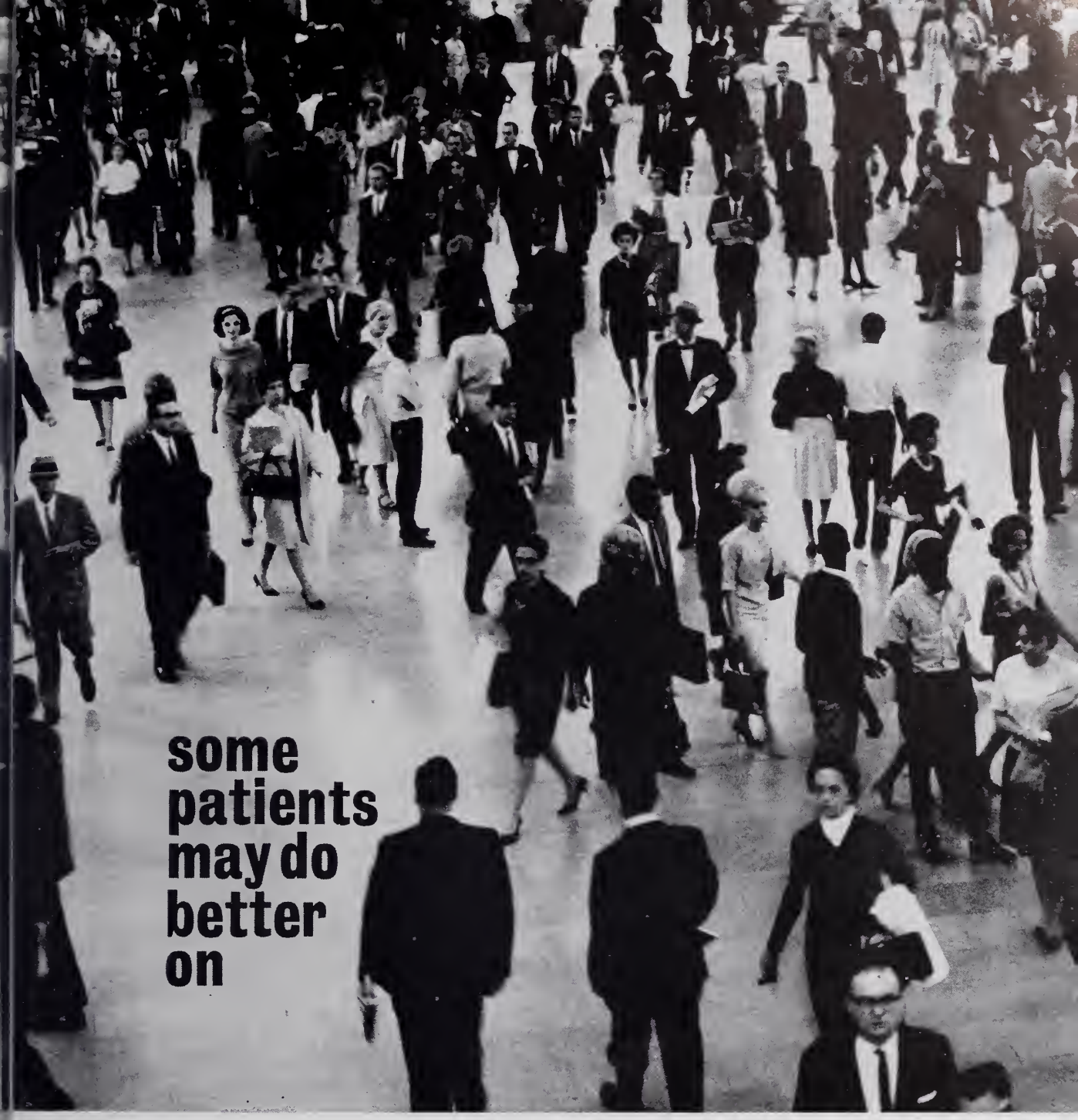
Dr. Annis said the King-Anderson bill "would transfer to the federal government at a single stroke the responsibility for the purchase of specified hospital and related benefits for all persons over 65, regardless of their desires or their economic need."

"There is no justification," he said, "for the use of tax funds collected from workers at the low end of the income scale to pay these expenses for the entire elderly population, including the self-supporting and the wealthy."

Dr. Annis declared that actuaries of the Department of Health, Education and Welfare had previously acknowledged in a study of the King-Anderson bill that "periodic tax increases will be necessary in a rising economy to keep the program solvent."

The AMA also pointed out that it has been estimated that it would cost $35 billion for King-Anderson benefits for the aged who would be immediately eligible but would have paid little or nothing under the program. "This is the amount," the AMA said, "that would be necessary to finance health care for the rest of their lives for all those eligible to take part in the program at its start." This figure was confirmed by HEW officials in Monday's testimony.

Norman A. Welch, M.D., Boston, president-elect of the AMA, appeared with Dr. Annis to review "the remarkable contribution toward the financing of health care for the aged that is being made by private health insurance and prepayment plans "which now protect more than 60 per cent of the entire population over 65."



ACHROCIDIN®

TETRACYCLINE HCl-ANTIHISTAMINE-ANALGESIC COMPOUND

Each Tablet contains:

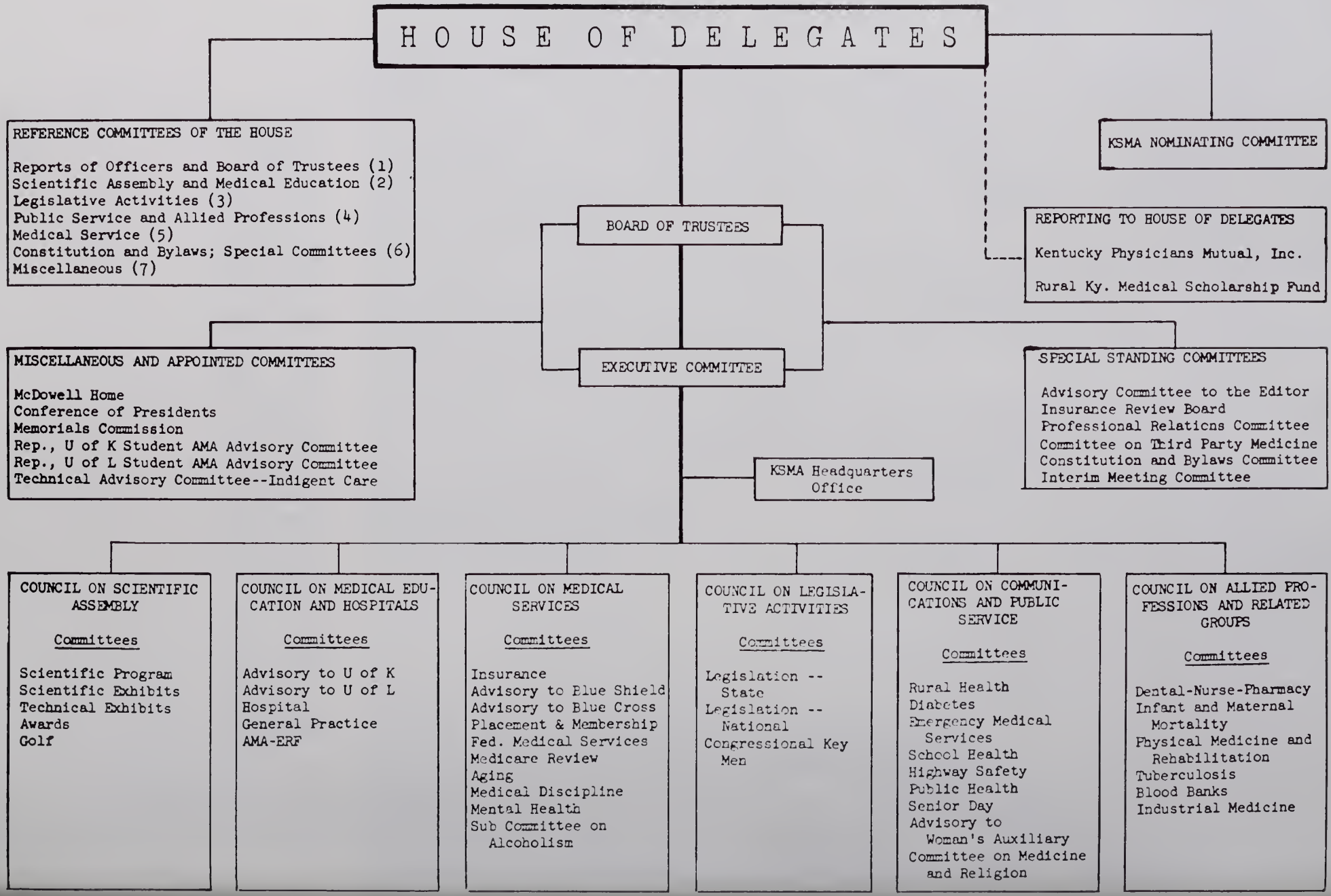
ACHROMYCIN® Tetracycline HCl	125 mg.	Caffeine	30 mg.
Acetophenetidin (Phenacetin)	120 mg.	Salicylamide	150 mg.
		Chlorothen Citrate	25 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms, tooth discoloration. The last named may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Average Adult Dosage: 2 Tablets four times daily.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

7142 3


HOUSE OF DELEGATES
REFERENCE COMMITTEES OF THE HOUSE
Reports of Officers and Board of Trustees (1)
Scientific Assembly and Medical Education (2)
Legislative Activities (3)
Public Service and Allied Professions (4)
Medical Service (5)
Constitution and Bylaws; Special Committees (6)
Miscellaneous (7)
KSMA NOMINATING COMMITTEE
BOARD OF TRUSTEES
REPORTING TO HOUSE OF DELEGATES
Kentucky Physicians Mutual, Inc.
Rural Ky. Medical Scholarship Fund
MISCELLANEOUS AND APPOINTED COMMITTEES
McDowell Home
Conference of Presidents
Memorials Commission
Rep., U of K Student AMA Advisory Committee
Rep., U of L Student AMA Advisory Committee
Technical Advisory Committee--Indigent Care
EXECUTIVE COMMITTEE
SPECIAL STANDING COMMITTEES
Advisory Committee to the Editor
Insurance Review Board
Professional Relations Committee
Committee on Third Party Medicine
Constitution and Bylaws Committee
Interim Meeting Committee
KSMA Headquarters Office
COUNCIL ON SCIENTIFIC ASSEMBLY
Committees
Scientific Program
Scientific Exhibits
Technical Exhibits
Awards
Golf
COUNCIL ON MEDICAL EDUCATION AND HOSPITALS
Committees
Advisory to U of K
Advisory to U of L
Hospital
General Practice
AMA-ERF
COUNCIL ON MEDICAL SERVICES
Committees
Insurance
Advisory to Blue Shield
Advisory to Blue Cross
Placement & Membership
Fed. Medical Services
Medicare Review
Aging
Medical Discipline
Mental Health
Sub Committee on Alcoholism
COUNCIL ON LEGISLATIVE ACTIVITIES
Committees
Legislation -- State
Legislation -- National
Congressional Key Men
COUNCIL ON COMMUNICATIONS AND PUBLIC SERVICE
Committees
Rural Health
Diabetes
Emergency Medical Services
School Health
Highway Safety
Public Health
Senior Day
Advisory to Woman's Auxiliary
Committee on Medicine and Religion
COUNCIL ON ALLIED PROFESSIONS AND RELATED GROUPS
Committees
Dental-Nurse-Pharmacy
Infant and Maternal Mortality
Physical Medicine and Rehabilitation
Tuberculosis
Blood Banks
Industrial Medicine



TRIPLE SULFA THERAPY is safe at levels of pH 5.5 or lower where the possibility of crystalluria would be greatest.

TRI-AZO-MUL
TRI-AZO-TAB

TRI-AZO-MUL

Each 100 cc contains:

Sulfadiazine (Microcrystalline)	3.381 gm.
Sulfamerazine (Microcrystalline)	3.381 gm.
Sulfamethazine (Microcrystalline)	3.381 gm.

In a palatable, stable emulsion pleasantly flavored with True Raspberry Flavor. Each average teaspoonful (80 min.) represents .5 gm. (7.7 grs.) of three combined sulfa drugs in suspension. Supplied in pint bottles only.

CONTRAINDICATIONS: Sulfonamides are potent drugs, and may cause toxic reactions. Sulfonamides, therefore, should be given only under constant supervision of a Physician.

TRI-AZO-TAB

Each tablet represents:

Sulfadiazine	0.166 gm. (2.57 gr.)
Sulfamerazine	0.166 gm. (2.57 gr.)
Sulfamethazine	0.166 gm. (2.57 gr.)

Available in White or Pink colored tablets in bottles of 100, 500 or 1,000.

TRI-AZO-MUL (citrated) offers the same formula as TRI-AZO-MUL (plain) with sodium citrate (17.5 gm.).

First Texas
Pharmaceuticals, Inc.
DALLAS • ATLANTA • Since 1901

Another Established Need Product . . . .

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS — 1963-1964

GEORGE P. ARCHER, Prestonsburg ..... President
DELMAS M. CLARDY, Hopkinsville ..... President-Elect
DAVID M. COX, Louisville ..... Immediate Past President
CARLISLE MORSE, Louisville ..... Vice President (Central)
CARL C. COOPER, Bedford ..... Vice President (Eastern)
JOHN DICKINSON, Glasgow ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, Corbin ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
DOUGLAS E. SCOTT, Lexington ..... Chairman of the Board of Trustees
GABE A. PAYNE, JR., Hopkinsville ..... Vice Chairman of the Board of Trustees

DELEGATES TO THE A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Murray (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

BOARD OF TRUSTEES

First District ..... O. LEON HIGDON, Katterjohn Building, Paducah 1965
Second District ..... HOWELL J. DAVIS, 330½ Allen Street, Owensboro 1964
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville (serving interim term) 1964
Eighth District ..... DON JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1964
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1964
Eleventh District ..... HUBERT JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... CLYDE C. SPARKS, Mayo Arcade, Ashland 1964
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

BUYERS GUIDE

JOURNAL OF KENTUCKY STATE MEDICAL ASSOCIATION, JANUARY, 1964

Ames Company 91
Baker Laboratories 62-63
Burroughs Wellcome 7-74
Chatham Pharmaceuticals, Inc. 75
Chicago Medical Society 73
City View Sanitarium 69
Coca-Cola Company 82
Cleveland Clinic Educational Foundation 68
Endo Laboratories 83
Fairmount Clinic 75
First Texas Pharmaceuticals 89
Geigy Pharmaceuticals 70
Glenbrook Laboratories 17
Hart Laboratories 76
The Keeley Institute 61
Lederle Laboratories 14-15-87
Eli Lilly & Company 18
Medical Protective Company 82
New Castle Sanitarium 8
The Emerson A. North Hospital 67
Parke, Davis & Company 2
Roche Laboratories 92
A. H. Robins Company 77
G. D. Searle & Company 87
Smith Kline & French Laboratories 11
Southern Optical Company 8
E. R. Squibb & Sons 3
M. R. Thompson, Inc. 13
Union Carbide Chemical Company 61
Veterans Administration Hospital 84
John T. Vie Company, Inc. 68
Wallace Laboratories 9-81-85
Winthrop Laboratories 5-79

neither **tension**, nor **spasm**,
nor **stasis**
stays this patient
from his
appointed rounds



DECHOLIN-BB®

. . . . . especially when
UPPER G.I. COMPLAINTS
have biliary implications

Each Tablet Contains:

for nervous **tension** → BUTABARBITAL SODIUM 15 mg (¼ gr.).
WARNING: May be habit forming

for smooth-muscle **spasm** → BELLADONNA EXTRACT 10 mg. (⅙ gr.).

for biliary/intestinal **stasis** → DEHYDROCHOLIC ACID 250 mg. (3¾ gr.).

Average adult dose: 1 or, if necessary, 2 tablets three times daily. **Precautions:** Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction; caution drivers against possible drowsiness. **Side effects:** Dehydrocholic acid may cause transitory diarrhea; belladonna may cause blurred vision and dry mouth. **Contraindications:** Biliary tract obstruction, acute hepatitis, glaucoma, prostatic hypertrophy. **Available:** DECHOLIN-BB, bottles of 100 tablets. **Also:** DECHOLIN® with Belladonna (dehydrocholic acid, 250 mg.; belladonna extract, 10 mg.) and DECHOLIN® (dehydrocholic acid, 250 mg.), bottles of 100 and 500 tablets.

AMES COMPANY, INC
Elkhart • Indiana
Toronto • Canada

345R263

LIBRIUM®
(chlordiazepoxide HCl)
the successor
to the tranquilizers

ROCHE

In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment. Caution should be exercised in prescribing any therapeutic agent for pregnant patients. Supplied—Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.

FEBRUARY 1964 • VOLUME 62 • NUMBER 2

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION

COLLEGE OF PHYSICIANS
FEB 24 1964



In This Issue

The Definition of Thyroid Status
Daniel G. Lareau, M.D. 115

Adenomyosis — A Tissue Committee Analysis
M. David Orrahood, M.D. 120

Dyspareunia Due to Conditions of the Introitus
Harold W. Baker, M.D. 122

Office Obstetrics
Denzil G. Barker, M.D., and Evelyn Mottram, R N 125

Roentgenography of the Breast
Arthur Lieber, M.D. 126

Early Treatment of Pulmonary Abscess
W Porter Mello M.D. 133

Complete Contents on Page 96

KSMA Interim Meeting April 23
Jenny Wiley State Park, Prestonsburg, Ky.

Helps to make the epileptic's life more meaningful

Dilantin® Kapseals®
(Diphenylhydantoin sodium)

PARKE-DAVIS

Effective in control of grand mal and psychomotor seizures, this agent enables the epileptic patient to lead a useful life.

Indications: Grand mal epilepsy and certain other convulsive states. **Precautions:** Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia has been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232



New Books and Editions



New! The 1964 CURRENT THERAPY VOLUME

This just-revised annual volume gives you today's most successful treatments for nearly 400 common diseases and disorders—from abscess to zoster, from the common cold to alcoholism. Over 300 eminent contributors to *1964 Current Therapy* have sifted hundreds of new treatments and drugs—discarded the outmoded, retained those still most effective, and added the new and more successful. These concise but thorough descriptions of treatment methods bristle with practical facts and brisk instructions. Exact dosages are given and prescriptions written out where necessary. This year's volume contains 237 articles in which some significant changes have been made in the treatment method. Here are but a few: *Newer knowledge and Therapy of Chorea—Use of Flagyl in Therapy of Trichomoniasis—Management of Transfusion Reactions and Shock—The New Vaccine for Prevention of Measles—Treatment of Episodic Cerebral Circulatory Syndrome—Streptokinase and Fibrinolysin in Treatment of Stroke—Newer Agents in Therapy of Bacterial Pneumonia—Effective Measures in Managing Hemochromatosis and Hemosiderosis—Improvements in Cardiac Pacemaker—Newer Treatment of Salmonella Infections—Therapy of Neurogenic Raynaud's Syndrome.*

An Annual Volume. Edited by HOWARD F. CONN, M.D., with contributions from 320 Leading Authorities. About 815 pages, 8" x 10½", $13.00. *Just Ready!*

New! Reuter's ATLAS OF UROLOGIC ENDOSCOPY

Here is a beautifully illustrated and effective new guide to the urologic uses of the endoscope. A highly informative introductory section discusses modern instruments, recent developments in endophotography, and other technical advances. Dr. Reuter covers the technique of cystoscopy and techniques of transurethral diagnosis and surgery. He illuminates the details of transurethral prostatic resection. Precise instructions are included for handling the resectoscope, and such useful procedures as electrocoagulation with the button electrode are described. The second half of the book is devoted to a diagnostic atlas of magnificent endoscopic views, most reproduced in full color, and accompanied by a brief legend giving the history and symptoms of the patient and the techniques of examination (angle of vision, peculiarities of lens and irrigation, degree of bladder distention). Here are but a few of the many conditions and anatomical views that are pictured: *Subacute follicular cystitis—Many varieties of bladder stones—Dome of atonic bladder—Stricture of the bladder neck—Sarcoma of the bladder—Erupting prostatic abscess—Many views showing results of transurethral prostatectomy—adenoma of the prostate.*

By H. J. REUTER, M.D., Private Urologic Hospital, Stuttgart, Germany. Translated by HUBERT G. W. FROHMÜLLER, M.D., Fellow in Urology of the Mayo Clinic, Rochester, Minnesota. 114 pages, 6⅝" x 9½", with 178 figures, 105 in color. About $15.00.

New—Just Ready!

New (2nd) Edition! Bockus' GASTROENTEROLOGY

Volume I published January, 1963 (Esophagus and Stomach). Volume II Just Ready (Intestines, Colon and Peritoneum). Volume III Ready September, 1964 (Liver, Biliary Passages, Gall Bladder, Pancreas). This is the *New (Second) Edition* of a monumental work on *all known primary and secondary disorders of the digestive tract and its appendages.* Each disorder is discussed in a logical pattern: causative factors, clincial features, diagnostic aids, differential diagnosis and therapy. Illustrations are used lavishly. Many are in vivid color. Included in the two volumes now completed you'll find new chapters on: *Oral Manifestations of Internal Disease; Tests Employed in the Study of Esophageal Function; Protein-Losing Gastroenteropathies; The Acute Abdomen; Peritoneoscopy; Lymphangiography; etc.* You'll find a new section of endoscopic views of the esophagus and stomach in magnificent color. This revision incorporates all the advances made in the fields of cytology, radiology and biochemistry as they relate to gastroentcrology. Newer and more effective methods of therapy are evident throughout.

By HENRY L. BOCKUS, M.D., Emeritus Professor of Medicine, University of Pennsylvania Graduate School of Medicine. With contributions from 31 former and present associates at the University of Pennsylvania Medical Schools. Three volumes, totalling about 3000 pages, 7" x 10", with about 600 illustrations, *many* in color. **Volume I,** *Esophagus and Stomach,* 958 pages, 298 illustrations. $25.00. *Published January, 1963.* **Volume II,** *The Small Intestine, Absorption and Nutrition, The Colon, Peritoneum, Mesentary and Omentum, Gastrointestinal Parasites,* about 1280 pages, with about 200 illustrations. About $28.00. *Just Ready.* **Volume III,** *Liver, Biliary Tract and Pancreas, Secondary Gastrointestinal Disorders, ready September 1964.*

New (Second) Edition!

W. B. SAUNDERS COMPANY West Washington Square, Phila. 5, Pa.

Please send and bill me: ☐ Easy Pay Plan ($5 per month)

☐ *1964 Current Therapy* . . . $13.00 ☐ Reuter's *Urologic Endoscopy* . . . About $15.00

Bockus' *Gastroenterology* . . . ☐ Vol. One $25.00. ☐ Vol. Two About $28.00. ☐ Vol. Three (when ready)

Name . . . . . .

Address . . . . . .

SJC 2-64

VOLUME 62 • January 1964
Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Sam A. Overstreet, M.D.

• ASSOCIATE EDITOR
Walter S. Coe, M.D.

• MANAGING EDITOR
J. P. Sanford

• ASST. MANAGING EDITOR
Ann M. Huntsman

• DEPARTMENTAL EDITORS
Jack L. Chumley, M.D., Scientific
Eugene H. Canner, M.D., Baak Reviews
Oscar J. Hayes, Case Discussians
W. Vinsan Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR
George F. Brackman, M.D., Chairman
Willett H. Rush, M.D.
Blaine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Moare, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1966
Harold L. Bushey, M.D.
Edward J. Fadell, M.D.
Merle W. Fowler, Jr., M.D.
Joseph L. Goldstein, M.D.
John D. Lovett, M.D.
George F. McAuliffe, M.D.
Ralph G. Thomas, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965
McHenry S. Brewer, M.D.
Lewis Dickinson, M.D.
Zygmunt Gierlach, M.D.
Douglas L. Gillim, M.D.
Arthur H. Keeney, M.D.
James B. Stith, M.D.
Chester B. Theiss, M.D.
Kearns R. Thompson, M.D.

Term Expires July 1, 1964
Herbert L. Clay, Jr., M.D.
Orville T. Evans, M.D.
M. Randolph Gilliam, M.D.
John Gardinier, M.D.
Franklin B. Maasnick, M.D.
William Oldham, M.D.
Howard W. Ripy, M.D.
Samuel M. Smith, Jr., M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205
Subscription $8.00—single copy .80
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

The Definition of Thyroid Status and Detection of Factitious Test Results by Combined RAI Uptake and PBI Determination
Daniel G. Lareau, M.D. 115

Adenomyosis — A Tissue Committee Analysis
M. David Orrahood, M.D. 120

Dyspareunia Due to Conditions of the Introitus
Harold W. Baker, M.D. 122

Office Obstetrics
Denzil G. Barker, M.D., and Evelyn Mottram, R.N., C.M. 125

Roentgenography of the Breast
Arthur Lieber, M.D. 128

Early Treatment of Pulmonary Abscess
W. Porter Mayo, M.D. 133

CASE DISCUSSION

The Role of Surgery in Carcinoma of the Uterine Cervix
Ben Eiseman, M.D., L. Norton, M.D., and Phillip Crossen, M.D. 135

SPECIAL ARTICLE

Kentucky's Medical Care Program Passes Third Successful Birthday
G. L. Simpson, M.D. 138

EDITORIALS

To Save a Life 140
Senior Day 1964 141

ORGANIZATION SECTION

Problems to be Analyzed by Top Speakers at Interim Meeting 144
Dr. Denham Elected Head of Ky. Hause Majarity 145
Board of Health Elects Dr. Higdan President 145
Ky. General Assembly Hears Talk by Dr. Annis on Kerr-Mills 146
Members Urged to Support State and Local C. of C. 147
Board Asks Caunty Sacieties to Hear Delegates Speak 147
Fees to be Charged far Haspital Surveys 148
Lexington Clinic Conference Scheduled for April 1 148
How to Reach Yaur Congressman on Current Health Matters 150
Senior Day Pragrams Planned at U.K. and U. af L. 150
American College af Physicians Hanors Eight Kentuckians 152
Staff Appointments and Changes Announced by U. af L. 152

REGULAR FEATURES

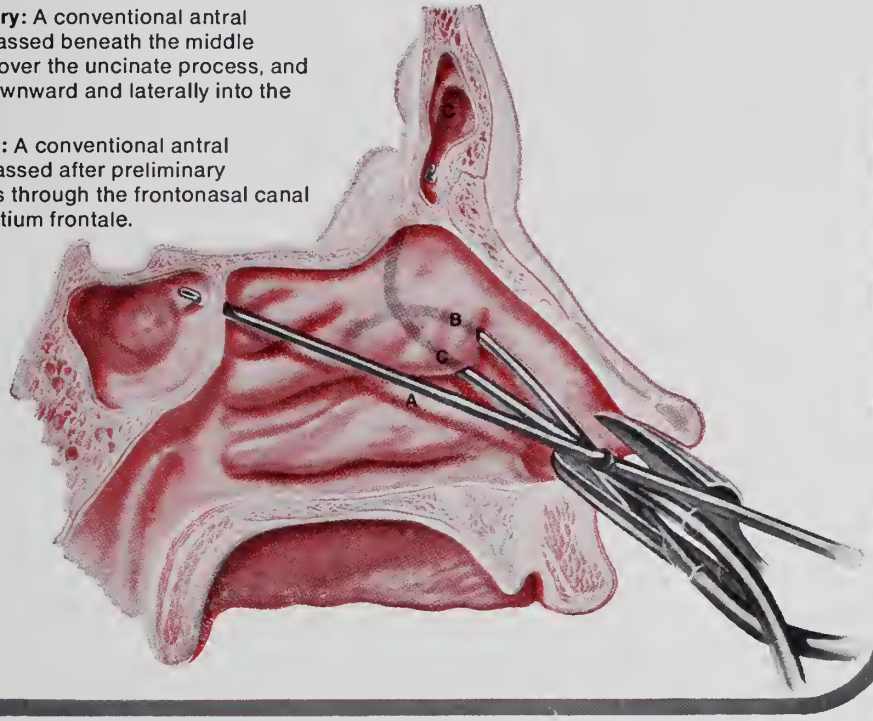
President's Page 98
Insurance Page 106
Public Health Page 108
Answers ta Yaur Questions an Blue Shield 111
Postgraduate Opportunities 142
In The Books 170
Maternal Mortality Page 173

A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

C—Frontal: A conventional antral cannula passed after preliminary maneuvers through the frontonasal canal into the ostium frontale.



In colds and sinusitis

Neo-Synephrine® sooner

hydrochloride
(Brand of phenylephrine hydrochloride)

can help prevent emergency measures later

Before complications arise in colds and sinusitis, Neo-Synephrine solutions and sprays reduce nasal turgescence on contact — to promote essential aeration and drainage. Turbinates shrink, sinus ostia open and drainage is freed. Relief is instant and the threat of complications is lessened.

In the treatment of sinusitis, the ¼ per cent solution is a preferred vasoconstrictor, "...most closely approximating physiologic composition with the least 'rebound' tendency...."* Gentle Neo-Synephrine is well tolerated by delicate respiratory tissues. Systemic effects are practically nil, post-therapeutic turgescence is minimal and repeated applications do not lessen its effectiveness. Neo-Synephrine has been a standard among vasoconstrictors since 1935.

Available in plastic nasal sprays for adults (½%) and children (¼%), in solutions of ⅛, ¼ or 1 per cent.

*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

Winthrop Laboratories
New York, N. Y.

Winthrop

(1839M)

MESSAGE FROM THE PRESIDENT



Supporting the Auxiliary*

MIXED feelings color the greetings that I bring you from the Woman's Auxiliary to KSMA: pride that I serve this year as state representative of over 1300 dedicated members who devote much time and effort to furthering the work of the Auxiliary and the cause of medicine; sorrow that there are over 900 other wives of KSMA members not represented by me or the Auxiliary.

To some of you I bring ardent pleas to give us your wholehearted, active support in our campaign to make our membership comparable to yours. In counties with too few in number to form an Auxiliary, urge your wives to join as Members-at-Large. In counties with Auxiliaries, encourage your wives to enroll. In counties with a large medical population but no Auxiliary, promote the formation of one.

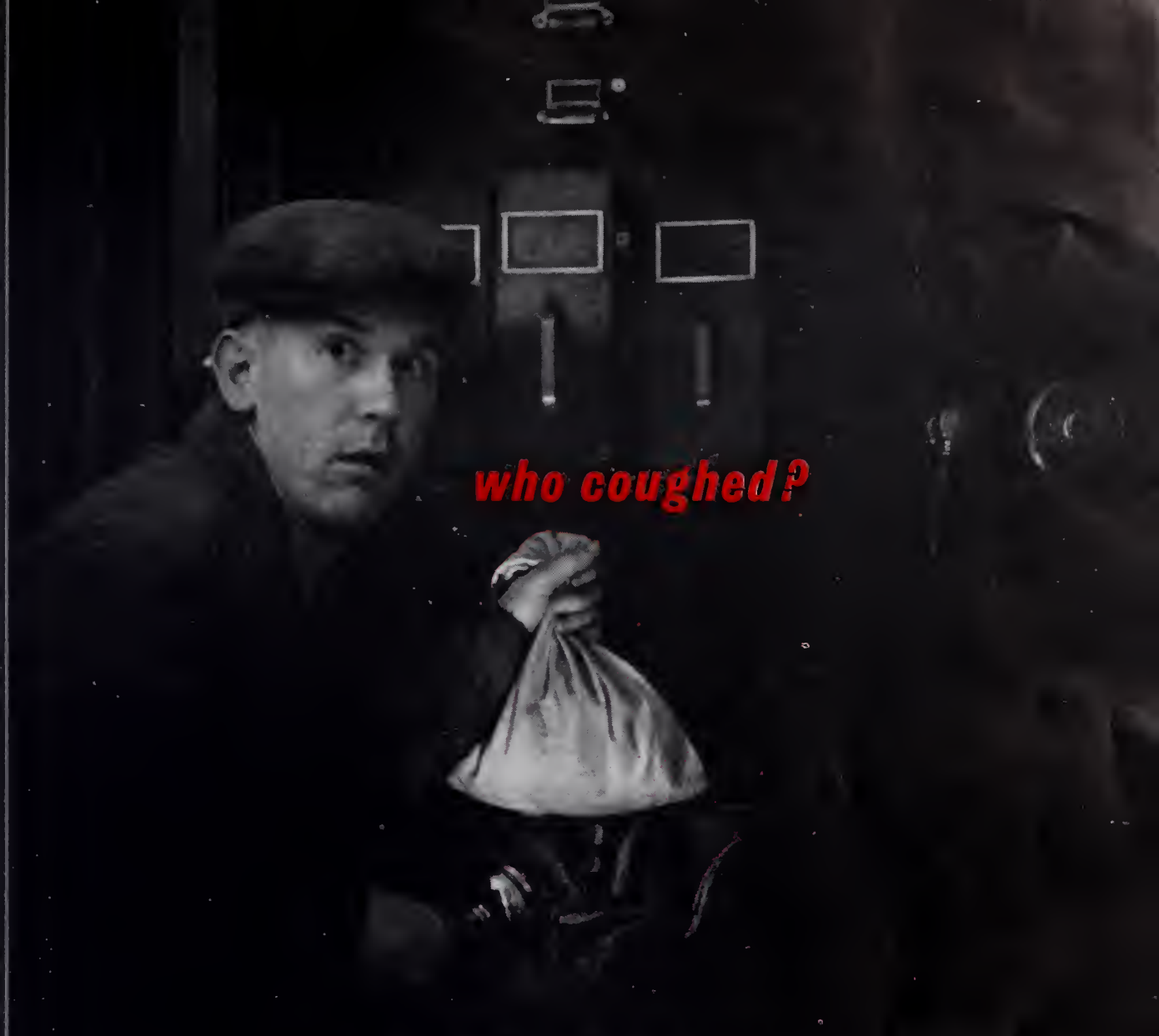
The Auxiliary is dedicated to service, but sometimes it needs to be stimulated, guided, challenged. I call upon you in your local groups to make full use of your Auxiliary in answering the demands of your community for active participation and leadership. What better way to extend your service than to encourage the Auxiliary to participate fully in community projects?

There is no community without problems to be solved and needs to be met. As doctors you are in constant contact with your communities and know first-hand the many areas where help is needed. Challenge the Auxiliary to help find the solutions and to be a motivating force for community betterment.

It is a female prerogative to grumble about all we are called on to do, but we need to be needed and like to be asked to assume responsibility and to work for civic improvement. Pay your wives the compliment of setting high goals for them and expecting superior performance. They will reward you — and your community — with successful accomplishments.

Mrs. J. Murray Kinsman, President
Woman's Auxiliary to KSMA

**This is the first of a series of guest articles written by the president of the Woman's Auxiliary and the vice presidents of KSMA at the request of KSMA president George P. Archer, M.D.*



for fast and long-lasting cough control

HYCOMINE® SYRUP

Each teaspoonful (5 cc.) contains:

Hycodan®	
Hydrocodone bitartrate . . 5 mg.	
(Warning: May be habit-forming)	6.5 mg.
Homatropine methylbromide 1.5 mg.	
Pyrilamine maleate	12.5 mg.
Phenylephrine hydrochloride	10 mg.
Ammonium chloride	60 mg.
Sodium citrate	85 mg.

in a highly palatable, cherry-flavored vehicle (methylparaben 0.13% and propylparaben 0.02% as preservatives)

INDICATIONS: For both productive and nonproductive cough. For relief of symptoms in tracheitis, bronchitis, pneumonia, pharyngitis, bronchial asthma, pertussis, and allied conditions; cough associated with allergy; in general, whenever cough medication is indicated.

DOSAGE: Average adult dose—1 teaspoonful after meals and at bedtime with food. Children 6 to 12 years, ½ teaspoonful; 3 to 6 years, ¼ teaspoonful; 1 to 3 years, 10 drops; 6 months to 1 year, 5 drops; after meals and at bedtime. On oral Rx where state laws permit. U. S. Pat. 2,630,400.

CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine HCl and in patients with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients use should not exceed three days. Hycomine Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur. May be habit-forming.

Endo®

Literature on request

ENDO LABORATORIES Richmond Hill 18, New York



who were the "untreatables"?

From their inception with cortisone, to the present-day variants of the steroid molecule, the corticosteroids have presented a therapeutic paradox. The beneficial action against inflammation and allergy as well as several undesirable metabolic effects are all, apparently, the results of the same basic physiologic action.[1]

Some of these associated metabolic reactions made it risky or otherwise undesirable to treat with steroids large numbers of patients in various categories who would otherwise have benefited from such management. These "untreatables" were overweight, had cardiac disease, hypertension, or pulmonary fibrosis associated with congestive heart failure. Also in this category were those patients whose emotional symptoms were aggravated by earlier steroids.

But the advent of ARISTOCORT® Triamcinolone in 1958—the result of biochemical and pharmacologic research which successfully stripped away many important undesirable hormonal effects from the primary anti-inflammatory action—dramatically changed this picture. This steroid did not overstimulate the appetite, or cause the excessive weight gain induced by other steroids;[2-7] it proved to have one of the best records of any steroid for *not* causing edema, or salt-and-water retention;[2,3,7-10] and the incidence of undesirable euphoria with this agent was remarkably low.[2,4,5,9,10] What is most significant is that these benefits have stood the test of more than 5 years of widespread use. And, of course, the avoidance of these distressing hormonal effects benefited *all* patients requiring steroids, not just those in the special categories, as demonstrated by wide clinical use.

Side Effects. Since it may, under some circumstances, produce any of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.

Contraindications. While the only absolute contraindications are tuberculosis and herpes simplex, there are some relative contraindications (peptic ulcer, glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

While no steroid can *cure* a susceptible disorder, many patients who would otherwise be confined in a state of invalidism have, on ARISTOCORT® Triamcinolone, been able to pursue active, useful lives.

References: 1. Levine, R.: Rationale for the Use of Adrenal Steroids, Paper presented at Annual Convention, Medical Society of the State of New York, New York, May 13-17, 1963. 2. Hollander, J. L.: Clinical Use of Dexamethasone. *JAMA 172*:306 (Jan. 23) 1960. 3. Boland, E. W.: Chemically Modified Adrenocortical Steroids. *JAMA 174*:835 (Oct. 15) 1960. 4. McGavack, T. H.: The Newer Synthetic Adrenocortical Steroids in Therapy. *Nebraska Med. J. 44*:377 (Aug.) 1959. 5. Freyberg, R. H.: Berntsen, C. A., Jr., and Hellman, L.: Further Experiences with Δ1, 9 Alpha Fluoro, 16 Alpha Hydroxyhydrocortisone (Triamcinolone) in Treatment of Patients with Rheumatoid Arthritis. *Arthritis Rheum. 1*:215 (June) 1958. 6. Cahn, M. M. and Levy, E. J.: Triamcinolone in the Treatment of Dermatoses. *Amer. Practit. 10*:993 (June) 1959. 7. AMA Council on Drugs: New and Nonofficial Drugs. *JAMA 169*:255 (Jan. 17) 1959. 8. McGavack, T. H.; Kao, K.-Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: Clinical Experiences with Triamcinolone in Elderly Men. *Amer. J. Med. Sci. 236*:720 (Dec.) 1958. 9. Fernandez-Herlihy, L.: III. Use and Abuse of Corticosteroid Therapy—The Structure and Biologic Activity of the Corticosteroid Hormones and ACTH, *Med. Clin. N. Amer. 44*:509 (Mar.) 1960. 10. McGavack, T. H.: Triamcinolone: A Potent Anti-inflammatory Sodium Excreting Adrenosteroid. *Clin. Med. 6*:997 (June) 1959.

maximum steroid benefit—minimum steroid penalty

Aristocort®
Triamcinolone
1 mg., 2 mg. or 4 mg. tablets

Lederle LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
229-3

Pardon Me!



FOR EFFECTIVE CONTROL . . . OF MOST UNNECESSARY COUGHS

A POTENT antitussive and expectorant (without sugar)

TOLU-SED®

(For prompt relief of a wide variety of coughs, including those associated with colds, bronchitis, throat irritations, influenza, asthma, smoking, smog, dust irritation, and excessive use of the voice.)

EACH FLUID OUNCE CONTAINS:	
64.8 mg.	**CODEINE PHOSPHATE***—For its well-known actions in suppressing unnecessary and nonproductive coughs, AND to decrease the viscosity of sputum.
6 mg.	**CHLORPHENIRAMINE MALEATE**—To correct those allergic components which may be due to histamines. (The antihistaminic may contribute the usefulness of this preparation if locally released histamine plays a role in the process which causes the bronchial irritation.)
600 mg.	**GLYCERYL GUAIACOLATE**—To increase the fluidity of respiratory tract secretions. This action decreases the irritating effect of inspissated mucus and facilitates its removal.
2.5 gr.	**TOLU**—Because Tolu has been found useful on an empirical basis for coughs of diverse etiology.
2 min.	**CHLOROFORM**

***Contraindications:**

Codeine phosphate may be habit forming. In very large doses it may depress respiration.

Availability: Pints and Gallons

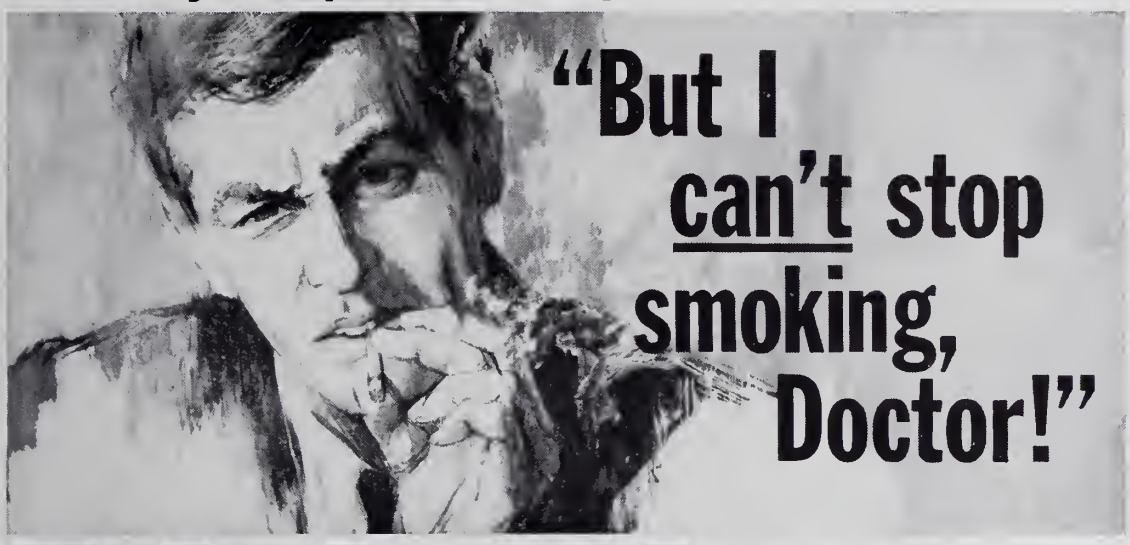
Administration and Dosage:
For Adults: 1 teaspoonful which may be repeated every 3 or 4 hours.

For Children over 6 years of age: ½ teaspoonful every 4 hours if necessary.

First Texas *Pharmaceuticals, Inc.*

DALLAS • ATLANTA • SINCE 1901

When your patient says:



Nikoban® PASTILLES

BRAND OF LOBELINE SULFATE, MRT

help curb the smoking habit

- Help induce a feeling of satiety similar to that of tobacco because of lobeline's pharmacological relationship to nicotine.
- Permit the patient to indulge his oral fixation by substituting the NIKOBAN Pastille for tobacco.
- Utilize the anorexic effect of lobeline to help the patient who is driven to compulsive eating when he discontinues smoking.
- Encourage patient cooperation through pleasant taste.

Dosage and Administration: In order to obtain the maximum benefit, a NIKOBAN Pastille should be sucked slowly and taken according to the schedule below. Whenever possible a pastille should be taken after meals.

1st week: 1 pastille every 1 to 2 hours for a maximum of 12 pastilles daily. *2nd week:* 1 pastille every 3 hours. *3rd week:* 1 pastille every 4 hours. *4th week:* 1 pastille every 4 to 6 hours. *Thereafter* 1 pastille may be taken at infrequent intervals whenever necessary. In some instances there may at first be a slight astringent burr of the tongue and throat. This will usually disappear as treatment with NIKOBAN Pastilles progresses and is no cause for concern.

Caution: It is advisable neither to smoke nor to use a smoking deterrent during pregnancy.

Formulation: Each NIKOBAN Pastille contains 0.5 mg. lobeline sulfate in a pleasant tasting spiced-cherry base.

Availability: In packages of 50 pastilles.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, Macmillan, 1960, Ed. 2, pp. 620-622; 2. Edmunds, C. W.: J. Pharmacol. and Exper. Therap., 1:27, 1909; 3. Hazard, R. and Savini, E. Gand., 92:471, 1963. 4. Dorsey, J. L.: Ann. Int. Med., 10:628, 1936; 5. Rasmussen, K. B.: Ugeskr.laeger, 118:222, 1956; 6. Ejrup, B.: Sven. lak. Tid., 53:2634, 1956; 7. Jochum, K. and Jost, F.: Munch. med. Wchnschr., 103:618, 1961; 8. Jost, F. and Jochum, K.: Med. Klin., 54:1049, 1959; 9. Smoking and Health, Summary and Report of the Royal College of Physicians of London on Smoking. New York, Pitman, 1962.

M. R. THOMPSON, Inc., Medical Department- BB
711 Fifth Avenue, New York, New York 10022

Gentlemen:
Please send me a trial supply of NIKOBAN Pastilles.

NAME _____ M.D.

ADDRESS _____

CITY _____ ZONE ____ STATE _____

TYPE OF PRACTICE _____

M. R. THOMPSON, INC. • NEW YORK, NEW YORK 10022

ARTHRALGEN® helps free



ARTHRALGEN®

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.

Arthralgen, a better-tolerated analgesic formulation of time-tested ingredients, works faster to free the arthritic from his pain without salicylate side effects. Since its analgesic components require no chemical conversion to act in the body, Arthralgen's pain relieving benefits are immediately available to provide a smoother, more rapid obtundation of pain than can be achieved with many true salicylates.

Arthralgen is especially useful for the prompt relief of early morning stiffness and pain with less risk of gastric irritation. And since Arthralgen contains no sodium it is safe for long-term use in arthritics who have other conditions which neces sitate sodium restriction.

ARTHRALGEN®-PR

Each tablet contains:

Salicylamide	250 m
Acetaminophen	250 m
Ascorbic acid (Vitamin C)	25 m
Prednisone	1 m

The basic Arthralgen formulation plus predni sone is indicated for patients who require steroid Prednisone has three advantages over cortison hydrocortisone, and ACTH. They are: (1) lack sodium retention, (2) absence of increased pota sium excretion, and (3) the unlikelihood of steroi induced hypertension.*

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated the management of rheumatoid arthritis, acu

arthritic joints from



I



N

uty arthritis, rheumatoid spondylitis, osteoar- itis, bursitis, fibrositis, and neuritis. Arthralgen y be used for analgesia in colds, flu, and ious myalgias.

)SAGE: One or two tablets four times a day. ter remission of symptoms, dosage should be luced to the minimum maintenance level.

)E EFFECTS: Nausea, GI upset, or mild salicy- m may rarely occur. Symptoms of hypercorticoid- n dictate reduction of dosage of Arthralgen-PR.

ECAUTION: Reduction in dosage of Arthral- n-PR given over a long period should be gradual, ver abrupt.

)NTRAINDICATIONS: Hypersensitivity to any gredient.

with any drug containing prednisone, Arthral- n-PR is contraindicated, or should be adminis- tered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

A. H. ROBINS CO., INC.
RICHMOND, VIRGINIA



THE INSURANCE PAGE



Major Medical Coverage

A RECENT report from the Health Insurance Institute reveals that the American public is becoming increasingly aware of the advantages offered by major medical health insurance protection.

Major medical is the fastest growing health insurance in the United States. In 1957, 13.3 million persons had this type of coverage. By the end of 1962, more than 40 million people had major medical protection—an increase of 27 million in five years.

In every year since 1960, more than 60 percent of the new group health insurance coverages which were written, have contained major medical provisions. In 1963, it was estimated that 64 out of every 100 persons acquiring group health insurance had this type of coverage. Twenty-eight percent of all group health policies now contain this provision. In 1962, almost seven billion dollars in benefits were paid to those who had this coverage.

Nearly nine out of ten new group major medical policies being sold today are of the "Supplementary" type, which means that the major medical insurance acts as an extension of basic hospital and medical-surgical plans. In other words, most group policy holders prefer to add major medical to the existing coverage, rather than completely revise their programs.

There are still many individuals who feel that insurance should pay for the smaller costs of medical care, such as home and office visits, and the ordinary drug expenses. Such coverage is available to those who desire it, but it offers no real advantage, since these costs are fairly predictable, and can be readily met by careful budgeting, without creating undue hardship.

The economic strain of prolonged illness involving heavy expenses, on the other hand, could completely destroy the financial solvency of many American families, and could create at least temporary hardship for most families.

The amazing growth of major medical coverage during the past decade is a clear indication that the public is aware of the above hazard, and welcomes the opportunity to protect itself against this hazard.

W. VINSON PIERCE, M.D.



In Chronic Illness: B and C vitamins are therapy

An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS, containing therapeutic quantities of vitamins B and C, is formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

7514-A

PUBLIC HEALTH PAGE

Community Health Services*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health, Commonwealth of Kentucky

WHEN we ask ourselves what major trends are currently affecting community health facilities and services, the first that comes to mind is the appearance of chronic diseases as a major health problem.

A child born in 1900 could look forward to 47 years of life, but an infant born in 1955 could look forward to an average life expectancy of almost 70 years. In other words, in a little more than 50 years, the average life span had increased approximately 50 percent. This remarkable increase in longevity has, of course, resulted in a larger percentage of elderly persons in our population.

In the United States, the population over 65 years of age has more than doubled since 1900. At the turn of the century, 4.1 percent or 3.1 million people were over 65; however, in 1962, 9.3 per cent or 17.3 million were over 65 years of age. Projected to 1980, and barring a major catastrophe, this figure is expected to rise to 24.5 million or 10 percent of the total population.

Faced with such data, it would seem that any community planning for health facilities and services would need to place major emphasis on the development of programs for the chronically ill and aged.

The Community Health Services Program in the Kentucky State Department of Health was established to help meet the consequences of this trend and has as its objective the establishment of programs principally for the chronically ill and aged.

On-Going Programs

In implementing the Federal Community Health Services and Facilities Act of 1961, the Kentucky Community Health Services Program has developed an organized Home Care Program which provides physical therapy, nutrition, and public health nursing consultation under the guidance of physicians in private practice.

The purposes of this program are to give the patient the advantages of comprehensive medical and other supportive services at home and in the familiar surroundings of his family, to restore the patient to normal family routine and activities of daily living as soon as possible, and to shorten institutional stay for selected patients.

Another factor to consider in planning community health services and facilities is that in the past almost any type of custodial care was termed "nursing home" care. As long as a home provided a bed for a patient, the place became known as a nursing home.

The trend, however, is for more and more nursing homes to have an organized medical staff; for patients in the home to be admitted by and under the supervision of a physician; for a registered nurse to be supervisor of nursing; and for the nursing home to have an affiliation with an acute general hospital. These are some of the criteria that separate and designate the nursing home as a medical care facility, and not just a place for an elderly person to receive custodial or personal care.

The Nursing Home Program of Community Health Services is dedicated to the promotion and development of this kind of nursing home by providing consultation on nursing home administration, by developing and conducting training programs for nursing home personnel, and by preparing materials to provide information and guidelines for efficiency. In addition to administrative consultation, the Nursing Home Program also provides consultation in the area of nutrition and rehabilitation.

Project Grants

Another major function of Community Health Services is to stimulate and assist public and nonprofit agencies of local communities in developing and securing special project grants. These projects may be studies, demonstrations, or experiments focused on the development of new or improved methods of providing out-of-hospital health services particularly for the chronically ill and aged persons. For the most part, project grants are designed to aid local communities in developing services that may be new to a locale or to test new ideas.

Community Action

The development of project grants represents community action to meet local needs for an ever-aging population, and the Community Health Services Program of the Kentucky State Department of Health is available to assist in the planning and development of project grant applications and the implementation of such projects.

**This article was prepared by: Evan J. Ray, M. P. H. Assistant Director, Community Health Services, Kentucky State Department of Health, 275 East Main Street, Frankfort, Kentucky.*



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193



When you prescribe for nasal congestion...

remember 'Empirin' Compound to relieve common cold discomfort



Also: 'Empirin'® Compound with Codeine Phosphate*
gr. ⅛—No. 1/gr. ¼—No. 2/gr. ½—No. 3/gr. 1—No. 4
*Warning—may be habit forming



Answers To Questions About Your

BLUE SHIELD

1. Q. May the Kentucky Physicians Mutual Service Report be used for filing claims with another Blue Shield Plan?
   A. *Yes. Most Blue Shield Plans can process a claim using the Kentucky Physicians Mutual Service Report. Those who cannot, upon the receipt of the report, will send you the required form.*

2. Q. How can I find what the coverage code indicates on the Blue Shield identification card?
   A. *Charts identifying the codes are included in the front of the new Participating Physicians Manual for the new Blue Shield Schedules C and D, we well as Standard and Preferred Blue Shield. Explanations of the contracts and endorsements are also included.*

3. Q. When an accident is involved, how do we know whether to file a Blue Shield Claim?
   A. *An accident is not a determining factor in providing Blue Shield benefits except in filing for accident X-rays. (Blue Shield basically provides surgical schedules with allowances for operating and cutting type procedures and allowances for the treatment of fractures and dislocations. No Blue Shield allowances are made for first aid.)*

4. Q. Is there a time limit on accident X-rays?
   A. *Yes. All accident X-rays must be taken within 30 days of the accident for the members to be eligible for benefits.*

5. Q. How are allowances provided by the Blue Shield contracts for lacerations?
   A. *They are based on the type contract held by the member, location of the wound on the body, the number of lacerations, the length and depth of the wound, and whether the laceration is jagged and requires extensive debridement.*

"They keep saying I'm sloppy!"



Nicozol® helps you restore your geriatric patients' interest in themselves

NICOZOL therapy can help you brighten the outlook of your aging patients who tend towards (1) untidiness, (2) irritability, (3) incompatibility, (4) lack of interest, and (5) loss of memory or alertness.

The NICOZOL formula helps improve mental acuity, increase the supply and use of oxygen in the brain, improve peripheral circulation—without excitation, depression, or other untoward effects.

NICOZOL can help you keep your aging patients actively alert and at ease with themselves, their families, and others.

Supplied: NICOZOL tablets (and capsules) in bottles of 100 and 1000. NICOZOL elixir in pints and gallons.

Precautions: May produce overstimulation in high doses. Discontinue if muscular twitchings or clonic convulsions occur. The flush produced in sensitive individuals is transient and harmless.

Average Dose: 1 to 2 tablets (or capsules) 3 times a day. 1 teaspoonful elixir 3 times a day.

Formula: Each tablet or capsule contains:
Pentylenetetrazol.....100 mg.
Nicotinic Acid.....50 mg.
Each teaspoonful (5 cc.) elixir contains:
Pentylenetetrazol.....200 mg.
Nicotinic Acid.....100 mg.
(as the sodium salt)
Alcohol.....5%

HART | Division of A. J. Parker Co. LABORATORIES Bryn Mawr, Pa., Winston-Salem, N.C.

NICOZOL®



The discharged mental patient . . . and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. *27*:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

SK&F *Smith Kline & French Laboratories*



a split hair from perfect...

THESE STAINLESS-STEEL PINS TAKE ON THE APPEARANCE OF TINY FLAMING CANDLES BECAUSE OF THEIR HIGH POLISH.

This pin is 0.00032 of an inch larger than perfect. As a result, it is rejected. ■ Stainless-steel pins like this are used to mold Lilly capsules. From each tray of three hundred new pins, fifty are selected at random. The diameter, length, taper, contour, and finish are carefully measured. If the sensitive electronic measuring devices show an imperfection beyond the hairsplitting limits, the entire tray of three hundred is rejected. ■ Lilly quality control draws the line at ± 0.0003 of an inch for some dimensions and ± 0.0005 of an inch for others. A split hair can mean the difference between perfection and rejection . . . another of the many important controls that add immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U. S. A.

Lilly

400169

The JOURNAL of the
Kentucky State Medical Association

Issued Monthly Under the Direction of the Board of Trustees

VOLUME 62 FEBRUARY, 1964 No. 2

The Definition of Thyroid Status and Detection of Factitious Test Results by Combined RAI Uptake And PBI Determination

Daniel G. Lareau, M.D.†
Owensboro, Ky.

Results from the use of these two tests in evaluating 127 cases suggest that this combination may utilize the diagnostic advantages of each while exposing the frequent sources of error of the other.

CLINICAL observation, especially if repeated over a prolonged period of time, will usually decide if the initial impression of thyroid function in a patient was correct or not. Tests of thyroid function are useful mainly to obviate prolonged observation as well as to document the validity of the initial clinical impression. Furthermore as shown by Chapman and Maloof,[1] in atypical cases the clinical picture may be so unclear that confidence in diagnosis is virtually impossible without confirmation by multiple thyroid tests. But these test results may be misleading as a result of previous medication which neither the patient nor the physician recalls. Also, no test is free from laboratory or clerical error. The question thus arises of how many times a test should be repeated or how many different tests should be performed.

The present study is an attempt to answer this question by showing the high accuracy obtained by using the radioactive iodine (RAI) uptake and protein bound iodine (PBI) determination together, to define thyroid function as well as to detect factitious test results. Adding the basal metabolic rate (BMR) determination in doubtful cases failed to increase accuracy. This latter is in agreement with numerous studies showing the superiority of the first two over the BMR.[2,3,4,5,6]

Methods and Materials

1) The results of all PBI determinations and RAI uptakes done within ten days of each other without a change in thyroid or antithyroid medications intervening, unless so stated, were collected from the hospital files from 1950 to 1955*. The only patients excluded were several who had had only one test performed because the clinical picture was very typical or because of unforeseen situations such as the patient leaving the hospital. All cases in which both tests had been performed within ten days of each other were used, including grade IV cardiacs, nephritics, patients with toxic, or nontoxic, nodular or diffuse goiters and patients receiving, or with a history of having recently received, antithyroid drugs including iodine, propylthiouracil, methimazole and potassium thiocyanate. All tests except two were performed

†*At the time of writing, assistant professor of Medicine at the University of Kentucky College of Medicine, Lexington, Ky., and assistant chief of Medicine at the Veterans' Administration Hospital.*

**Departments of Medicine, Thayer Veterans Administration Hospital and Vanderbilt University, Nashville, Tenn.*

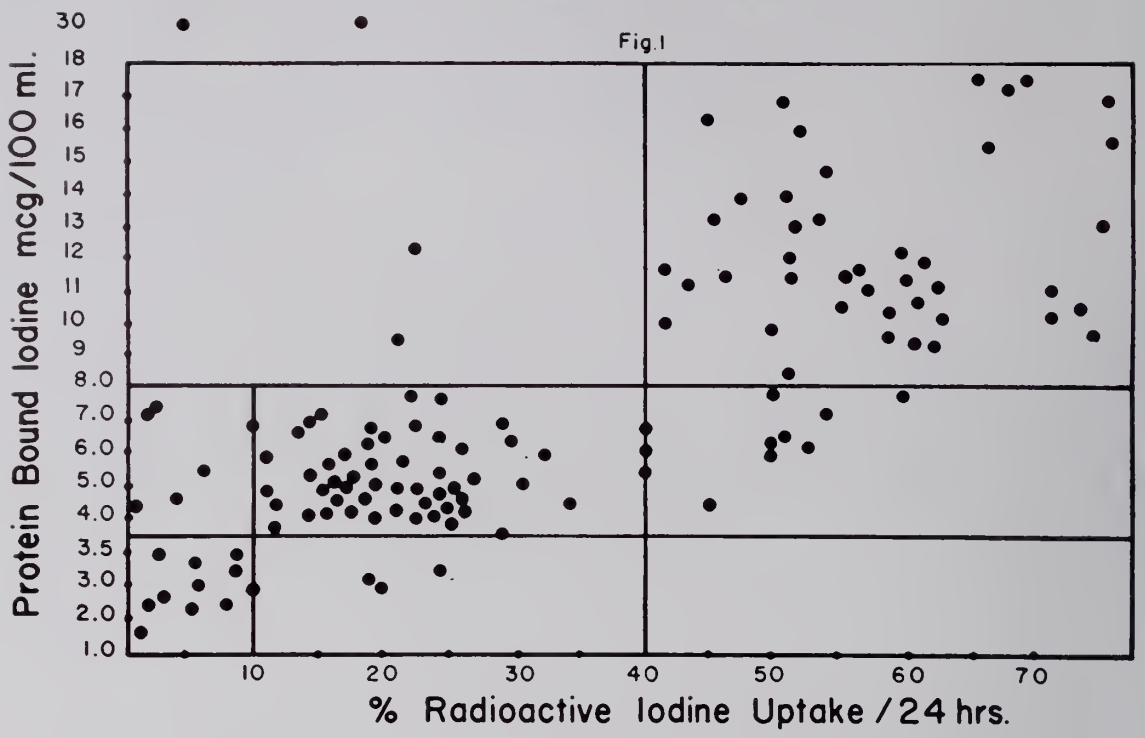


Fig.I. 127 test results of PBI and RAI combined showed the above distribution.

on male patients between the ages of 20 and 70 years. They numbered 127 sets of tests on 110 patients. The PBI was determined by the Barker method.[7] The RAI uptakes were measured with a well shielded scintillation counter using I-131 tracer doses of 5-10 microcuries,[8] the neck count being compared with the count of a duplicate dose of I-131 in a suitable phantom. Secondary radiation was excluded by means of an energy discrimination "gate" in the counting equipment.

All test results were plotted on a graph in which the PBI values were recorded on the ordinate and the RAI uptake results on the abscissa. It was believed this method of plotting would best illustrate areas of agreement or divergence between the tests. Appropriate labels were assigned to the various compartments formed by the intersecting boundaries of normalcy of the PBI and RAI to designate the presumptive diagnosis in each case, thus graphically cross-indexed with reference to PBI level and RAI uptake.

2) The BMR tests were done with a McKesson metabolator on patients sedated with a 100 mgm. capsule of secobarbital sodium at bedtime and again one hour before the test. They were taken to the testing station before breakfast via wheelchair to lie down in a quiet room for at least thirty minutes before testing.

3) All of the above patients were observed as long as necessary by the house staff and consulting endocrinologist. It is believed that the final diagnoses based on laboratory results and prolonged observation are reliable.

Results

Plotting the results of the combined tests as a dot representing the intersection of the PBI measured on the ordinate and the RAI uptake on the abscissa produced the distribution seen in Fig. 1. Compartments formed by the upper and lower boundaries of normalcy of both tests indicate zones (see Fig. 2) wherein both tests agree or disagree as to the thyroid status, the zones of agreement being 2, 4, and 6 representing hyperthyroidism, euthyroidism, and hypothyroidism, respectively. Of the 127 combined tests, 55 on 47 patients fell in the euthyroid compartment, 42 on 32 patients in the hyperthyroid, and 11 on 18 patients in the hypothyroid zone. In none of those cases was the diagnosis changed on the basis of additional testing and clinical observation. Thus, of a total of 127 combined tests, there was agreement of the PBI and the RAI in 108, and in these cases the accuracy was 100%.

The 19 other cases, in which the tests dis-

Fig. 2

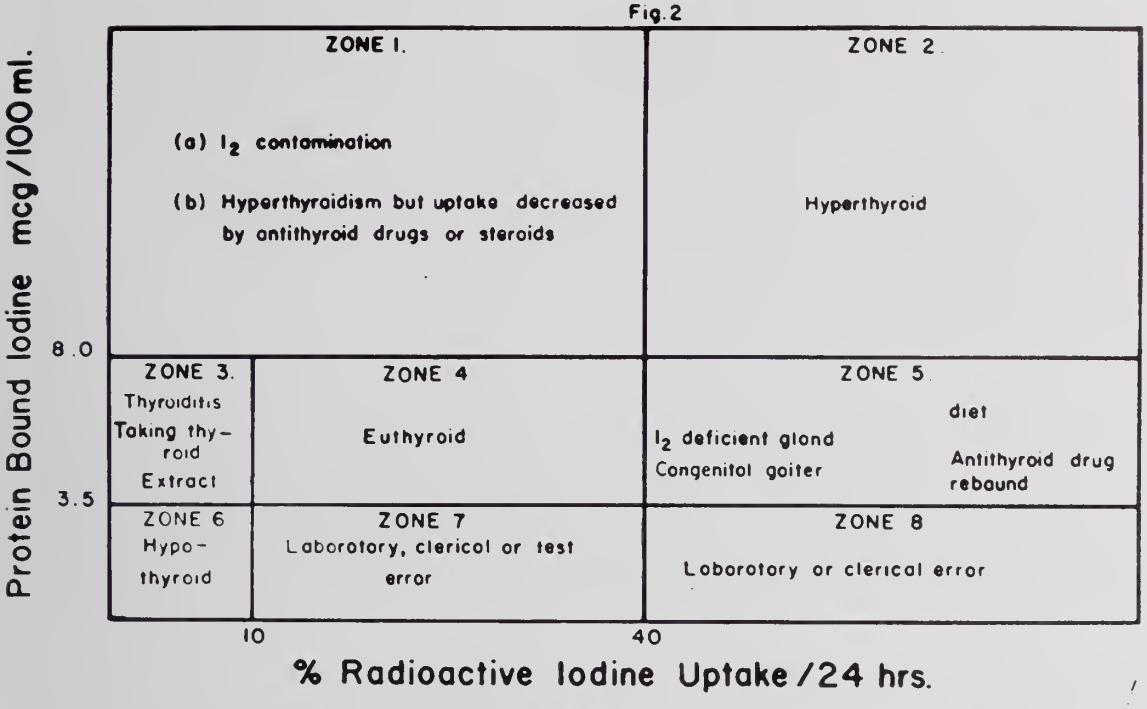


Fig 2 The most likely diagnosis, hereafter referred to as chart diagnosis, has been entered in each compartment formed by plotting the boundaries of normalcy of the PBI and RAI uptake tests.

agreed, could represent test error or the correct measure of two different aspects of thyroid function, the RAI uptake measuring present thyroid activity and the PBI measuring hormonal blood level from past thyroid production. Thus, a suppressed thyroid gland in a patient maintained on thyroid extract could be expected to have a low uptake, the PBI being normal. Causes of suppression would include iodine or thyroid extract ingestion, antithyroid drugs, thyroidectomy, thyroiditis, pituitary or thyroid failure, ACTH, corticosteroids, testosterone and others.[9]

Again, as iodine contamination and antithyroid drugs cause a decrease in the RAI uptake, similarly, the iodine deficient gland, whether from a low iodine diet or recently discontinued blocking agent, including antithyroid drugs and goitrogenic foods, would be expected to have an increased uptake of the iodide in the tracer dose.

Various reasons for disagreement without error in either test are shown in Fig. 2, and will be later referred to as the "chart diagnosis."

Reviewing the patients' hospital records for causes of discrepancy in each case of disagreement between the PBI and RAI uptake revealed the reasons listed in Table 1. It may be noted the actual reasons coincide very closely with those predicted in Fig. 2. Cases in which no reason for disagreement, or reasons other than shown in Fig. 2 were found, are marked with an asterisk.

Coincident BMR tests were obtained and the results are listed for 15 of the 19 cases in Table 1. It can be seen that BMR testing was incorrect or equivocal in 10 cases and that reproducibility was poor. Accordingly, it was concluded that the BMR did not add to the accuracy of the diagnosis in these cases in which the PBI and RAI uptake disagreed.

In this series of combined PBI and RAI uptake tests the accuracy in the chart zones, 2, 4, 6, where both tests agreed that the patients were hyperthyroid, euthyroid and hypothyroid, respectively, was 100%. The overall accuracy, following the "chart diagnosis" as in Fig. 2, was 96%. The PBI test alone had an accuracy of 89%, the RAI uptake test 87%.

Discussion

It might be debated that the high accuracy of either test alone renders superfluous the added accuracy of the combined tests. But an accuracy of 90% is misleading since this is only 40% better than the fifty-fifty result of

TABLE 1
Reasons for Disagreement Between PBI and RAI

Fig. 1	TVAH HOSPITAL NO.	PBI	RAI		
			Zone 1		
P. C.	47 814	30	4.3	IVP before tests	—6
E. M.	51 065	12.5	24	IVP 10 da before PBI IVP 21 da before RAI	+25, +16
M. J.	52 640	9.5	22	ACTH IV drip during uptake phase. Patient probably toxic	Asthma prevented doing BMR
M. L.	54 019	30	17	I_2 ingestion, RAI done 10 days after PBI	—24, +9
			Zone 3		
J. B.	49 986	5.8	5.4	3 mo. post I-131 therapy causing suppression of uptake	+13, +13
*O. A.	54 562	7.6	2.3	Patient Euthyroid RAI error	—35, —7
E. N.	48 790	4.8	4	Thyroidectomy + thyroid extract	—10
L. H.	54 471	5.3	1.1	Thyroidectomy + thyroid extract	—19, —34
*A. R.	55 515	7.3	2.2	Error of RAI, Patient euthyroid	+10
			Zone 5		
*G. J.	54 608	6.2 7.0	50 55	Error of RAI. Intractable CCF. Patient euthyroid	+30, +42 +31, +17
T. S.	50 196	6.7	51.5	I_2 def. -nodular goiter, non-toxic	+111, +4
S. H.	52 658	7.9	50	Borderline clinically as well as by repeated laboratory test	+38
*H. W.	54 864	7.9	61	Error of PBI	+20, +10
B. R.	52 699	4.5	46	"I_2 deficient" goiter	+82, +10
R. M.	44 420	6.3	54.4	"I_2 deficient" goiter	+7, —5
J. B.	55 031	6.6	54	"I_2 deficient" gland from previous KSCN Rx	+62, +15
			Zone 7		
*J. F.	51 133	2.1	20	Aortic and mitral insufficiency	-BMR could not be done because of dyspnea
*L. B.	54 473	2.3	18	Aortic and mitral insufficiency	"
*B. C.	53 318	2.6	25	Intractable CCF with chronic cyanosis	"

*** There was disagreement of the PBI and RAI uptake tests in the above cases constituting 15% of this series. The association of low PBI values and chronic dyspnea found in Zone 7 may have some explanation excluding error in test results. The BMR test failed to improve the diagnostic accuracy of the combined PBI and RAI uptake.**

chance alone. What of the other 10%? What if the test results were wrong due to lab error or unsuspected previously ingested medication? Here the clinician is in the position of a judge who would probably prefer the testimony of two different witnesses than two observations from the same witness. The same test could be wrong twice because of the same technical error or because of premedication, but, as demonstrated in this study, errors were few when two different tests were performed.

The compartmented chart presented in Fig. 2 is believed helpful in graphically illustrating the reasons for the divergence of the PBI and RAI uptake results which occurred in 15% of this

TABLE 2
Tabulation of Error of Chart Diagnosis from Fig. 2

CHART ZONE	NO. PTS.	NO. TESTS	CHART Dx RIGHT	PBI WRONG	RAI WRONG
1	4	4	4		
2	32	42	42		
3	5	5	3		2
4	51	55	54		
5	7	8	5*	1	2**
6	8	10	10		
7	3	3	3	3	
				4 tests	4 tests
	110	127	121	4 pts.	3 pts.

***One patient, S.H. TVAH 52 658, borderline hyperthyroid by repeated testing was also borderline clinically. **Two tests on the same euthyroid patient, G. J. TVAH 54 608, in intractable CCF, showed elevated RAI uptake. Subtracting a thigh count from the neck count as recommended by Astwood might have resulted in normal uptakes if the high uptakes were due to increased circulating radioactive iodine in the blood secondary to poor renal function. This would have increased the accuracy of the RAI test.**

series. Following the "chart diagnosis" alone would have given a 96% accuracy.

It is interesting to note that the correct diagnoses in this 96% include many conditions of the thyroid other than the usual divisions of hypo-, eu-, and hyperthyroidism. For example, zone 3 relates to euthyroidism without glandular activity and zone 1 relates to euthyroid status with normally functioning gland but high blood iodine due to contamination or recent thyroid hyperactivity.

Experience in this hospital where the PBI and RAI uptake tests are readily available makes it seem feasible to save the BMR for pre-thyroidectomy evaluation of hyperthyroid patients taking Lugol's solution and the occasional patient suspected of hyperthyroidism who has been examined with a bronchogram or myelogram in the past year. Patients receiving antithyroid drugs can be best evaluated with the PBI.

It appears from the findings in this study that the PBI determination and RAI uptake together constitute an adequate though simple "battery" of function tests sufficiently accurate to confirm and extend clinical observation and judgment.

Summary

A review of 127 combined PBI determinations and RAI uptake tests on 110 unselected patients showed a 100% accuracy when both tests agreed on the thyroid status. This was the case in 108 combined tests, or 85%. In the other 15%, disagreement as to low, normal, or high range of function was found due to fac-

titious reasons such as premedication or laboratory or clerical error.

The main factors known to cause divergence of the PBI and RAI test results were listed on a compartmented chart formed by the boundaries of normalcy of both tests plotted on the ordinate and abscissa, respectively. When the intersecting points of the 127 combined tests were plotted on the chart, the diagnosis of the compartment or zone in which the points fell was found to be 96% correct. The accuracy of the PBI alone was 89%, of the RAI uptake 87%.

It is believed the RAI uptake and the PBI determination done simultaneously approach the maximum accuracy to be expected from any "battery" of thyroid tests. Their exposure of factitious test results gives them an added advantage. With the addition of minimal clinical observation and judgment, final diagnostic accuracy should be virtually 100%.

Bibliography

1. Chapman, E. M. and Maloof, F., Bizarre clinical manifestations of hyperthyroidism. New Eng. J. Med. *254:* 1-5, 1956.
2. McAdams, G. B., and Salter, W. T.: Comparative tests of thyroid function. Ann. Int. Med. *26:* 1198, 1952.
3. Barrett, T. F.; Peck, H.; Bauer, F. K.; Libby, R. L., & Jarrett, S. R.: Evaluation of a thyroid panel. J.A.M.A. *152:* 1414, 1953.
4. Zieve, L., Skanse, B., and Schultz, A. L. Comparative value of the basal metabolic rate, chemical protein-bound iodine, and radioactive iodine excretion or uptake in the diagnosis of borderline hyperthyroidism when used individually or in combination. J. Lab. & Clin. Med., *45:* 281, 1955.
5. Roswit, B., Rozencrantz, J. A., Sorrentino, J., Yalow, R., Berlin I.: Evaluation of diagnostic methods in diseases of thyroid function with particular reference to radioiodine tracer tests Am. J. M. Sc. *223:* 29, 1952.
6. Jaffee, H. L., and Otooman, R. E.: Evaluation of radioiodine aest for thyroid function. J.A.M.A. *143:* 515, 1950.
7. Barker, S. B.: Determination of protein-bound iodine. J. Biol. Chem. *173:* 715, 1948.
8. Werner, S. C.; Quimby, E. H. and Schmidt, C.: The use of tracer doses of radioactive iodine, I-131, in the study of normal and disordered thyroid function in man. J. Clin. Endocrinol. *9:* 342-354, 1949.
9. Slingerland, Ward D.: The influence of various factors on the uptake of iodine by the thyroid. J. Clin. Endocrinol. *15:* 131, 1955.
10. Rapport, R. L.; Curtis, J. M.: The clinical significance of blood iodine: A review. J. Clin. Endocrinol. *10:* 735-790, 1950.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Adenomyosis—A Tissue Committee Analysis†

M. David Orrahood, M.D.*

Owensboro, Ky.

This paper discusses a study by the Tissue Committee of the Owensboro-Daviess County Hospital for the year 1961. There were several aspects to this study but only the diagnosis of adenomyosis is considered here. A distinction is made between adenomyosis and endometriosis.

ACCORDING to *Current Medical Terminology* (1962), adenomyosis is a disease characterized by dysmenorrhea and endometrial glands incarcerated in the uterus. On the other hand, in endometriosis, dysmenorrhea is not common and glands are placed with no connection to the endometrial cavity. To be aware of this is to understand how an apparently normal uterus can give dysmenorrhea which requires a hysterectomy.

Material

During 1961, 301 uteri were reviewed by the Tissue Committee. A pathological diagnosis of adenomyosis had been made in 74 instances. These 74 cases form the material of this study.

The established criteria for the microscopic diagnosis of adenomyosis were rigidly adhered to in this study.[1,2,3,4,5]

The average age of the patients was 39.4 years. The youngest was 26 and the oldest was 57 years old. The patients had an average of three children; however, seven had no children.

Symptoms and Signs

The symptoms are given in Table I.

Benson,[2] who noted a similar pattern in his 701 cases, states, "that adenomyosis cases plus other disease as fibroid when compared showed similar bleeding pattern; in other words, the presence of other disease did not seem to affect the symptom pattern."

Table I

Symptoms of Adenomyosis (74 Cases)	ODCH* 74 Cases	ISRAEL 307 Cases	BENSON 701 Cases
Menorrhagia	45%	55%	46%
Pain	41%	30%	—
Dysmenorrhagia	19%	22%	41%
Descensus	12%	—	—
Dyspareunia	8%	—	—
None	7%	—	—
Metrorrhagia	5%	37%	23%
Discharge	1%	—	—

*Owensboro-Daviess County Hospital

A distinction in the type of bleeding between a fibroid and adenomyosis was noted and is reported. A symptomatic fibroid tumor so placed as to interrupt the basalis of the endometrium is associated with continuous bleeding throughout the period while adenomyosis is characterized by abnormal bleeding with pain at menstruation.

According to Benson, slight enlargement and tenderness of the uterus, dysmenorrhea, and failure to make the diagnosis by D and C are sufficient grounds for the diagnosis of adenomyosis. In our cases, the uterus was enlarged in 44 instances, adhesions were present in 16, and tenderness was present in two. The reason for the low incidence of tenderness is not known. Perhaps it may be an unawareness or failure to report it.

Pre-Operative Diagnosis

The pre-operative diagnosis of adenomyosis is given in Table II.

Table II

Pre-operative Diagnois in Adenomyosis (74 Cases)	ODCH 74 Cases	ISRAEL 307 Cases	BENSON 701 Cases
Descensus	34%	59%	—
Leiomyoma	24%	61%	—
Adenomyosis	22%	2.6%	10%
Endometriosis	15%	—	—
Bleeding	28%	—	—
Cervix	4%	—	—
Ovary	3%	—	—
P.I.D.	3%	—	—

The concensus is in accord with our poor

†*Presented before the September 20, 1962 meeting of the Kentucky Society of Pathologists, during the Annual Meeting of the Kentucky State Medical Association.*

**Pathologist, Owensboro-Daviess County Hospital.*

correlation between pre-operative and pathological diagnosis of adenomyosis. Benson, for instance, notes that the clinicians at the University of Oregon suspected the diagnosis of adenomyosis in 10% of 701 cases, while Israel found this true in only 2.6% of 307 cases at the University of Pennsylvania.[2, 4]

Pathology

The pathological diagnoses are given in Table III.

Table III

Pathological Diagnosis in Adenomyosis	ODCH 74 Cases	ISRAEL 307 Cases	BENSON 701 Cases
Leiomyoma	27%	56%	57%
Endometriosis	8%	12%	13%
Sub-Involution	4%	—	—
Polyp, Endometrium	3%	—	—
Adhesions	1%	—	—
Others, unclassified	0	6%	—

Although deflection of glands was the sole criteria for the selection, other pathological findings were noted.

The routine description of uteri given by the Pathology Department consists of several measurements. Our normal values are a weight of less than 100 grams, a volume of less than 100 ml., a thickness of the myometrium of less than 2 cm., a length of less than 9 cm., and cervical diameter of less than 3 cm.

In this analysis, the average weight was 160 grams; the average volume, 160 ml.; the average thickness of myometrium, 2.8 cm.; the average length 10 cm.; and, the average diameter of the cervix, 3 cm. Thus these uteri were enlarged by weight and measurement, showed a thickened myometrial wall but retained the same size of the cervix as compared with our values for normal uteri.

Still another observation was the presence of fibroids in 27% of the 74 cases. This is a lower incidence than reported by either Benson or Israel. No relation was observed between adenomyosis and endometrial carcinoma. Marcus, however, in his series made this correlation.[5]

Discussion

Although adenomyosis is a well established disease, the surgeon and the pathologist do not always record it. Israel notes that "its preoperative diagnosis would increase if the clinician would think of adenomyosis in every white, parous, middle-aged woman suffering from menorrhagia and dysmenorrhea . . ." Perhaps the pathological diagnosis would be made more frequently if the glandular deflection was described and correlated.

The value of this study resides in the correlation of the hospital record with the pathological diagnosis. It is clear that these 74 uteri show little other disease. Without a diagnosis of adenomyosis, the cases must be given a diagnosis of a bleeding uterus. In either case, the criteria for justifiable surgery is met.

Summary

A study of 74 cases of adenomyosis is presented. A poor correlation between the clinical and pathological diagnoses was found. Many examples of bleeding uterus also met the pathological criteria for a diagnosis of adenomyosis.

References

1. Bayly, Melvyn A., and Yates, Christina J. "Adenomyosis and Abnormal Uterine Bleeding," Obstet. & Gynec. 10:276-278, 1957.
2. Benson, Ralph C., and Sneeden, Vinton D., "Adenomyosis: A Reappraisal of Symptomatology." Am. J. Obstet. & Gynec. 76: 1044-1061, 1958.
3. Gordon, Burgess L. and Talbott, John H. *Current Medical Terminology,* American Medical Association, Chicago, 1962.
4. Israel, S. Leon, and Woutersz, Theodore B., "Adenomyosis A Neglected Diagnosis," Obstet. & Gynec. 14:168-173, 1959.
5. Marcus, Cyril C., "Relationship of Adenomyosis Uteri to Endometrial Hyperplasia and Endometrial Carcinoma," Am. J. of Obstet. & Gynec. 82:408-416, 1961.

Dyspareunia Due to Conditions of the Introitus

HAROLD W. BAKER, M.D.*

Louisville, Ky.

In cases of dyspareunia the introitus is frequently the site of the trouble. Methods of diagnosing and treating such conditions are discussed. In severe cases plastic revision is necessary; steps of this operation are presented.

MANY states require a pre-marital physical examination. Depending on the physician, the examination may vary from sticking out the tongue and saying "Ah" to a complete history and physical examination, including pelvic examination. Increasing numbers of young women are seeking the latter type examination and as a result we are seeing many virginal girls.

By following a number of these patients after their marriage and by investigating women who have been married for several years. We have evolved a rule-of-thumb for predicting the manner in which the hymen and introitus are going to behave after the wedding. Therapy should be carried out according to the findings, if the young couple is to get off to a painless happy start. This information is given in Table I.

Table 1.
Evaluation of Hymen at Premarital Examination

Type	Therapy
1. Admits only one finger.	Hymenotomy, check for bands.
2. Tips of two fingers, painful	Hymenotomy, check for bands.
3. Two fingers; hymen elastic; minimal pain.	Lubricants. (Office dilatations).
4. Admits three fingers.	You're too late.

This problem is not always limited to the single girl preparing for marriage, but is found in women who have been married for some time. During the history part of the consultation these patients rarely mention that they have dyspareunia or that coitus is impossible: their "Chief Complaint" usually deals with other matters. It becomes important, therefore, for the physician to make a habit of checking the size of the introitus during the pelvic examination and if a tight opening is found, specific questions will quickly reveal whether any problem exists.

Illustrative Case

One dramatic case will serve as illustration. A thirty-nine year old patient was referred by an internist because of pressure pain in the pelvis and the finding of a large myoma. History revealed involuntary sterility during her eighteen years of marriage but no marital difficulties. On pelvic examination she was found to have a large myoma rising to the umbilicus but in addition her hymen would admit only the tips of two fingers. Discussion with her and the husband revealed the fact that they had never had intravaginal relations. The wife, who was quite intelligent and alert in other respects, had not been aware of this fact. The operating room team gave us quite a ribbing when they saw the scheduled surgery, "Total abdominal hysterectomy and avulsion of hymen."

It should be noted that multiple myomectomy was considered but rejected because of the marked distortion of the uterus. At the two month postoperative examination this couple expressed delight with their new discovery. I felt a deep sense of sympathy, however, when she asked, "if the lack of intravaginal relations was the cause of her infertility." My reply seemed to satisfy her; a white lie exaggerating the relationship between myomata and sterility.

Many men say the hymen is not unusually tender and that most of the pain is psychological. In the rare case I agree, but there is ample proof that a thick inelastic hymen is extremely sensitive to stretch. For those who doubt this statement I suggest the following experiment,

* *Associate professor of Obstetrics and Gynecology at the University of Louisville School of Medicine.*

which is the one we carry out on each avulsion of the hymen. With the patient under sodium pentothal and nitrous oxide anesthesia, put an Allis clamp on the buttocks to show that there is no response by the patient. Then question the anesthesiologist about the level of anesthesia to be sure the "phobia" centers are knocked out. Then force two fingers through the hymeneal opening and spread them apart, thereby stretching the hymen. The patient, almost without exception, will raise her hips several inches off the table and often there is the crowing sound of partial laryngospasm.

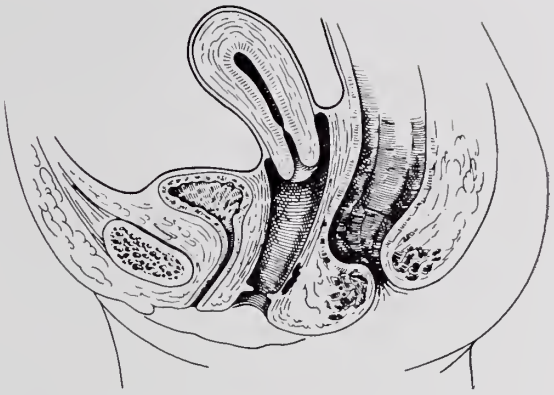


Figure I

Treatment

I prefer to avulse with two fingers, followed by three fingers, and then if necessary, any dense portions of the hymen may be severed with scissors. Rarely are sutures needed to control bleeding. I do not favor excision of the hymen due to the reports that show it is a more extensive operative procedure requiring a longer period for disappearance of tenderness and yielding a smaller, tenser opening than the avulsion.

In addition to the hymen the operator should check for bands across the rectovaginal septum about one centimeter inside the vagina. These are found in about one-fifth of patients who require avulsion. After completing the avulsion, if three fingers cannot be introduced easily, because of tightness in this area, these bands should be severed. The technique is quite simple; A 1 cm. longitudinal incision is made in the vaginal mucosa starting at 6:00 o'clock in the hymen; a finger is inserted into the rectum and brought forward tensing these bands; with the knife light strokes are made until the bands have been severed, leaving a normal elastic character to the rectovaginal septum. The mucosal incision is closed with fine catgut.

I prefer to do the avulsion three to four weeks before the wedding to insure a painless first union. In those cases which did not present themselves to the office sufficiently in advance of the wedding date and in patients already married but unable to have coitus, the patient has experienced relatively little pain if the first coitus is attempted one week postoperatively.

The patient is discharged from the hospital twenty-four hours after surgery. She undergoes a two finger vaginal dilatation once a week for the succeeding two to three weeks. Follow-up results show no pain on first coitus in practically every case. The three finger introitus is our guide in anterior and posterior colporrhaphies also, with a snug two finger diameter at the narrowest point higher in the vagina.

Figure I, shows a cross section of the pelvis with the hymen in white and the bands in black.

Cases are encountered in which simple hymenotomy and avulsion are not adequate. These are usually older women with atrophy or with stenosis following colporrhaphy or episiotomy. I have had six cases in which a special relaxing type of operation has been needed to keep the home in happy balance. In essence this operation is the opposite of a

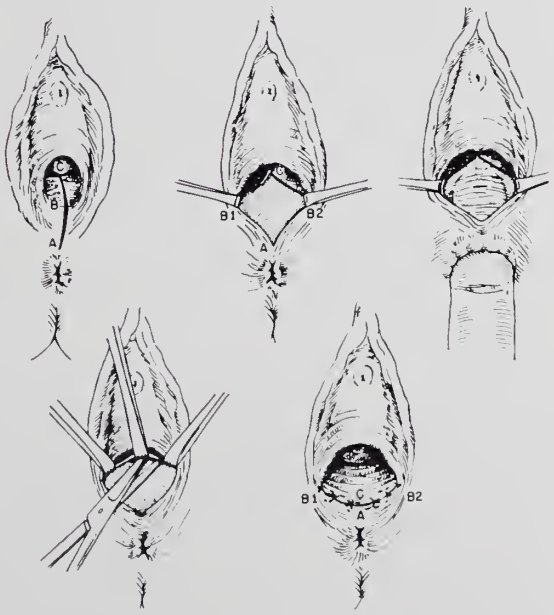


Figure II

posterior colporrhaphy and I deliberately produce a small rectocele. The old technique of a longitudinal incision and transverse closure is utilized.

Figure II, shows the steps of the operation. A longitudinal incision in the vaginal mucosa is begun about 3 cm. inside the hymen (C) and is carried through the hymen (B) and down onto the perineum to a point (A) about 1 cm. from the anus. The skin and mucosa are dissected free from the underlying tissue. A finger is inserted into the rectum and the transverse fibers of the perineal body are severed with the knife to a sufficient depth to produce a small rectocele. The mucosa is further freed so that it can be brought down to the skin edge without tension. Point (C) is sutured to point (A) and the remainder of the incision is closed with interrupted fine catgut. The following table summarizes these cases.

Case No. 2 was outstanding due to the fact that the transverse closure would have resulted in too small an opening; a split thickness skin graft 5 cm. square was taken from the thigh and sutured in place to the mucosa and skin to cover the diamond shaped defect. Seventy-five percent of the graft took and the remaining area granulated in well without scar formation and at the end of two months was covered with normal epithelium.

Operation For Enlarging Introitus

Patient	Age	Etiology	Results
1. V.S.	51	Perineorrhaphy	Excellent
2. G.B.	61	Senile atrophy, second marriage	Excellent
3. M.T.	17	Turner's Syndrome	Adequate
4. J.L.	36	Surgical menopause at age 31	Fair
5. S.G.	22	Hymeneal and rectovaginal scar, etiology unknown	Excellent
6. E.R.	54	Perineorrhaphy	Excellent

Summary

In summary, the hymen should be checked in premarital examinations and if necessary corrected surgically. Any married woman whose introitus is tight and tender during a two finger examination or during a medium Graves speculum examination should be questioned as to dyspareunia in the introitus region. An operative procedure for correction of defects offers excellent results.

April 23

is the date

for the

1964 KSMA Interim Meeting

at

Jenny Wiley State Park

Prestonsburg, Ky.

Office Obstetrics*

Denzil G. Barker, M.D., and Evelyn Mottram, R.N., C.M.

Hindman, Ky.

This paper points out the feasibility of office deliveries of normal cases and emphasizes some of the advantages of this practice, both for doctor and patient, over home deliveries.

FROM 1946 until 1959, almost all my patients were delivered in their homes, except for a few in the nearest hospital, some 19 miles away.

Because of the many undesirable aspects of home deliveries, and the fact that such procedure made me lose many hours from my practice, I decided to increase office space, employ additional assistance and start performing deliveries in the office. The added office space included a delivery room, three labor rooms, two bathrooms, a sterilizing room, a private office for secretary and bookkeeper, and two large examining rooms.

As I speak of "we", I refer to my enlarged office staff, which consists of my secretary-bookkeeper, who had already been with me several years, and now, in addition, a registered nurse-certified midwife, and a high school graduate employed as nurse's aide and receptionist, who has received on-the-job training. Furthermore, the help of my wife, a registered nurse, has been utilized on many occasions.

During the four-year period from March 6, 1959 until March 6, 1963, we admitted a total of 405 patients to the office maternity unit, from whom the statistics covered in this paper are drawn. 400 of these were delivered at the office. No home deliveries were done during this period, and relatively few deliveries in the small hospital referred to above.

Regular prenatal check-ups, at least once a month and often more frequent, especially late in pregnancy or if complications developed, were urged and virtually insisted upon. Printed sheets of instructions were provided during prenatal care and the puerperium.

Of the total number of patients delivered, 41 were delivered twice and six three times, during the four year period. Six patients were transferred to the hospital from the office. Of this number, five were transferred during labor and one after delivery. The latter patient was transferred as a precautionary measure, after a rather difficult removal of a retained placenta, but no further definitive treatment was needed, and she was released in about 12 hours. Of the five transferred during labor, usually for x-ray pelvimetry, (but one for delivery of second twin, as noted below), four delivered normally at the hospital. The fifth patient had delivered the first of twins at the office, then developed a retraction ring, and eventually had to have the second twin delivered, stillborn, by caesarean section. The first baby was quite depressed at birth and died in the hospital after about 12 hours.

Although the total number of deliveries is rather small, yet it is felt that there have been enough to have some statistical significance. The remainder of this paper will be concerned with some observations made on the patients in this series.

The average number of prenatal visits made was 3.86. This includes 12 patients of colleagues admitted by us, whose doctors were not available at the time of their labor, and who had prenatal care elsewhere, as well as four additional patients we had to admit in the late second stage of labor, who had had no prenatal care at all.

On admission in labor, each patient received fairly routine care, except as conditions required alteration, or lack of time necessitated certain omissions. Routinely, each patient was provided a gown, was shaved, and was given a soapsuds or Fleet® enema. Early in labor, sodium pentobarbital or secobarbital was often used for sedation, in dosages of one and a half to three grains. Later Mepergan® 1-2 cc. intramuscularly was used and repeated in three to

**Presented at the May 13, 1963 meeting of the Perry County Medical Society Meeting at Hazard.*

four hours, if necessary. If more sedation was needed, Demerol® combined with Sparine® was used, in dosage of about 50 mg. of each intramuscularly. If delivery was anticipated within two to three hours, Lorfan® or Nalline® was administered, along with the narcotic. When the patient was moved to the delivery room, sterile technique was instituted. Anesthesia at this stage consisted usually of pudendal nerve block and/or Trilene® inhalations, using a Duke inhaler.

Parity

The following table depicts the parity of the patients in this series:

Table 1

Gravida	1	2	3	4	5	6	7	8	9	10	11	12	13	14
No. of patients	92	72	58	46	34	31	17	18	14	3	6	4	4	1

As will be noted, the number of patients delivered was in inverse proportion to the parity, except in the few grand multiparas, and almost one-fourth of the total consisted of primigravidas.

Prenatal Complications

Table 2 is a list of complications encountered and their frequency:

Table 2

Toxemia	
Mild	41
Moderate	1
Severe	1
Hernia (left inguinal)	1
Pernicious vomiting	2
Hematuria	4
Bleeding during pregnancy	5
Appendicitis	1
Acute pelvic inflammatory disease	1
Pyuria	21
Hypertension	7
Kidney stone	1
Anemia	10
Alopecia	1
Severe varicosities	6
Pleurisy	1
Epilepsy	1
Bartholin cyst abscess	1
Thrombophlebitis	4
Biliary colic	1
Cellulitis (left ankle)	1
3rd degree prolapse of uterus	1
Fractured pelvis	1
Strep throat	1
Obesity	2
Rattlesnake bite	1
Mumps	1

The patient with kidney stone had operative removal by urologist when she was about two months pregnant, but her prenatal course subsequent to this, and delivery, were uneventful. One patient fractured her pelvis in a fall from a bridge when she was in the last month of pregnancy, but delivered a normal viable infant 19 days later, with no difficulty. One rather nervous patient developed alopecia areata early in her pregnancy, which progressed to totalis by term, but there was complete restoration of hair growth during the weeks following delivey. When about six months pregnant, one patient was bitten by a rattlesnake and was hospitalized and given polyvalent antivenin and supportive care. The residual edema of her foot and leg gradually subsided after her discharge from the hospital, and she had a normal delivery of a healthy infant, at term.

Mechanism of Labor

We ordinarily allowed most cases to deliver spontaneously, with as little interference as possible within the limits of safety, with the nurse-midwife administering anesthetic. The nurse-midwife delivered five of the patients in my absence and four patients had precipitate deliveries before I could get to them. Two other patients delivered before their arrival at the office. Mechanisms were as follows:

Table 3

LOA	220	Spontaneous breech	13
ROA	152	Breech extraction	9
LOP	6	Forceps (outlet)	3
ROP	1	Twins	7½
RMA	1	(see opening discussion)	

The very low incidence of forceps delivery (three cases out of 400) was due to our policy of non-interference noted above, together with the fact that my own preference when the fetal head is on the perineum is the use of ironing of the perineum, and if further stimulation is needed, judicious use of Pitocin® intramuscularly, starting with no more than one-half to one minim.

Babies

Male	212	Anencephalus	3
Female	189	Club foot	2
Stillbirth	6	Spina bifida	1
Prematures		Hydrocephalus	1
Lived	13	Fractured arm in (difficult) breech delivery	1
Died	4	Bell's palsy	1
Neonatal deaths	3	Hepatitis	1
True knot in umbilical cord	8	Erythroblastosis fetalis	1

The infant born with Bell's palsy, from pressure of forceps in difficult delivery, recovered completely within several days.

One interesting case was that of an infant who developed giant-cell hepatitis (diagnosed by pediatrician) soon after birth, with rather deep jaundice, but with eventual apparently

Table 5

Episiotomies performed	38
Lacerations	
1st degree	31
2nd degree	27
3rd degree	1
Pudendal block	41
Pitocin in 2nd stage	47
Abruptio placentae with stillbirth	1
Hematoma of labia	2
Induction	
Amniotomy	1
Amniotomy and Pitocin by i.v. drip	2
Placenta and fetus delivered together	
Live birth	1
Stillborn	1
Prolapse of umbilical cord	1
Umbilical cord broke during delivery	2
Manual removal of placenta	4
Average blood loss, all patients (measured)	137.75 c.c
Average ages of patients	
Primipara	20.4 (range 16 to 31)
Multipara	28.3 (range 17 to 45)

Table 5 supplies miscellaneous information on patients and their labors.

complete recovery. The mother had had infectious hepatitis two years beforehand, at age 16, and before her marriage, and this was thought to have a causal relationship in the case of the infant's disease.

The baby with erythroblastosis recovered after exchange transfusions at the Lexington Medical Center. The baby's mother was Rh negative and had given birth to several normal babies before this. The father could not be persuaded to have Rh typing nor would the mother have an Rh antibody titer test during this pregnancy.

Duration of Labor

The actual time of onset of labor in some instances was difficult to determine accurately, but the table below represents a fairly average time.

Table 6

Multipara	
First stage	7 hrs., 48 min.
Second stage	29 min.
Third stage	6 min.
Total: 8 hrs., 23 min.	
Primipara	
First stage	13 hrs., 21 min.
Second stage	60 min.
Third stage	6 min.
Total: 14 hrs., 27 min.	

Postpartum Complications

Table 7 presents the complications encountered following delivery of these cases, none of which eventuated in a maternal mortality.

Table 7

Postpartum hemorrhage	
Immediate (packs inserted in 2)	9
Delayed	
4 to 8 hrs.	2
5 to 7 days	5
Hypertension	13
Toxemia	4
Edema	2
Thrombophlebitis	3

Only one patient in the series had to be catheterized following delivery (once only). In two others, Foley catheters were inserted, however, because of lacerations adjacent to the urethral meatus, which, it was felt, might interfere with micturition. In neither case was the catheter left in more than 24 hours.

Summary

A tabulation has been made of some of the factors involved in office obstetrics. The advantages of this type of delivery over delivery in the home in a rural area become apparent. Both the patient and the physician benefit greatly by it. Following delivery, very few patients were kept at the office for as long as 24 hours, most of them being discharged and usually able to walk out to a vehicle, sometimes within as little as two or three hours. The average postpartal stay for all cases was 11 hours and 49 minutes.

Roentgenography of the Breast

Arthur Lieber, M.D.*
Lexington, Ky.

Soft tissue radiography of the breast is an accurate and simple procedure of considerable value in the detection of carcinoma of the breast. Its application to breast disease in general and carcinoma in particular is discussed.

MAMMOGRAPHY of soft tissue roentgenography of the breast without contrast injection is a simple procedure that offers a gross anatomical view of the whole living breast. Newer x-ray techniques allow differentiation of fibrous, glandular and fatty tissues to a degree which permits an accurate diagnosis of most breast lesions, particularly carcinoma.

Mammography has been performed for well over 25 years; however, notable progress in its application in the evaluation of the normal and abnormal breast has been made only in recent years mainly due to the efforts of Leborgne,[1] Gershon-Cohen,[2] and Egan.[3] The early lack of progress was due to unsatisfactory technique and lack of an exact pathological knowledge of the normal and abnormal breast.

Indications

There are many ways in which breast radiography can be helpful:

1) Breast nodule—The benign or malignant nature of a lump in the breast discovered by either the patient or the physician can be determined with high accuracy from its appearance on the mammogram. Egan, in a series of 2,522 mammograms interpreted without knowledge of clinical findings, correctly diagnosed 501 (96.7%) of 518 proved carcinomas and 351 (91.6%) of 383 proved benign lesions.[4]

2) Nipple changes—In the presence of nipple changes such as retraction, discharge or eczema, the radiograph can rule out a deep-seated malignancy when no abnormality is palpable.

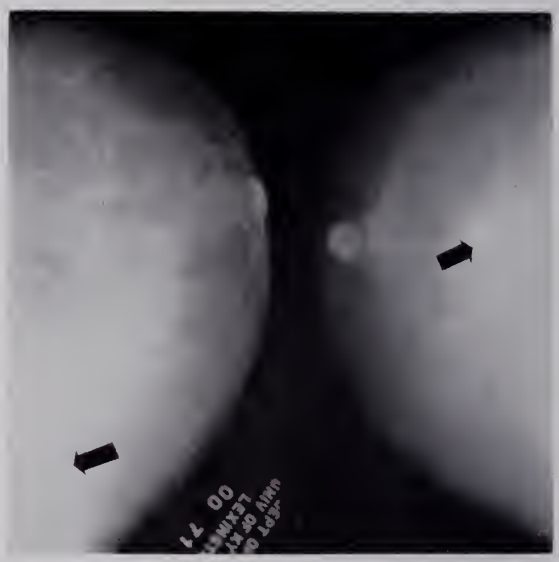


Figure 1. Bilateral breast carcinomas (arrows). Fifty-year old woman with large ill-defined mass in right breast. Preoperative mammography disclosed malignancy in opposite breast also.

3) Bilateral breast tumors—Before surgery for a definite malignancy in one breast, mammography is useful for excluding an occult carcinoma in the opposite breast (Figure 1).

4) Several nodules in one breast—In the presence of several masses within one breast, the radiograph may permit a more definite approach in selecting the most suspicious mass for biopsy. Re-examination after biopsy by roentgenography provides assurance that the most malignant appearing nodule actually has been removed.

5) Large, painful breast—A large, pendulous or painful breast is difficult to evaluate by palpation, but the x-ray easily penetrates this type of fatty breast.

6) Carcinomatosis—In the presence of metastatic malignant disease, mammography may prove quite rewarding in finding the primary site of the malignant tumor within the breast or in ruling out the breast as a source of metastases.

*Assistant professor of Radiology at the University of Kentucky Medical Center, Lexington.



Figure 2. Position for superior-inferior view of breast. Breast on cardboard film holder. Nipple in true profile.

7) Cancerophobia—The negative mammogram may offer considerable assurance to the patient with vague breast symptoms or to the patient concerned over a strong family history of breast cancer.

8) Type of anesthesia for breast surgery—Mammography may help determine the type of anesthesia planned for a breast biopsy. Endotracheal intubation may be carried out for a radical procedure if the nodule looks undoubtedly malignant on x-ray and simple anesthesia may be planned for biopsy of a lesion which appears benign on the x-ray.

9) Occult breast tumor—Egan discovered 53 unsuspected carcinomas on x-raying the breasts of 1,194 women[5] and Martin discovered 15 of these tumors on mammography in 571 patients.[6] It has been suggested that routine mammography on women over 40 years of age at six months or yearly intervals may yield a significant number of occult carcinomas. In order to evaluate this possibility, the National Cancer Institute is sponsoring a large scale study of periodic mammography on subscribers to the Health Insurance Plan of New York.[7]

10) Postoperative follow-up—Postoperative detection of breast cancer by periodic mammography of the remaining breast has shown itself to be useful. Byrne and others examined the remaining breast of 102 women by mammography at regular intervals. Six patients were found to have cancer in the remaining breast and in only one patient was the lesion palpable when it was first detected on the roentgenogram.[8]

Technique

A satisfactory technique for soft tissue roentgenography of the breast depends upon the use of an unfiltered low kilovoltage (25 - 35), high MAS (960 - 3200) x-ray beam and high definition, non-screen x-ray film. Industrial type x-ray film, such as Kodak M and AA, Ansco Super Ray A, or an equivalent film is most satisfactory. Attempts at reducing the skin radiation dose may be made by adding a filter of 0.5 mm. aluminum or increasing the development time from five to ten minutes although these factors decrease the resolution of the film slightly. An average target to skin distance is 24 inches. The gonads should be shielded by a lead apron.

Since it is difficult to show both the skin and internal structures on the same film with the same x-ray beam, two films in a cardboard holder separated by a one mm. thick sheet of aluminum will provide a properly exposed view of the deeper structures on the top-most film and a satisfactory demonstration of the skin and subcutaneous structures on the lower and partially shielded film.

Usually two views of the breast at a right angle to each other such as a superior-inferior view (Figure 2) and a lateral view (Figure 3)



Figure 3. Position for lateral view of breast. Cardboard film holder may have to be elevated from table top to keep breast in true profile.



Figure 4. Normal mature breast. Superior-inferior view shows central glandular tissue and peripheral trabeculae composed of ducts and their supporting connective tissue.

are sufficient. Occasionally an axillary view, in which the x-ray beam is centered to the apex of the axilla, may be necessary to demonstrate the axillary process of the breast and the axilla itself.

Contrast studies of the breast, using iodized oil or air introduced into the ducts through the nipple, have been found to be unsafe since these foreign materials have produced breast inflammation and abscesses.[9]

The Normal Female Breast

The appearance of the female breast on x-ray is influenced by age, nutritional status, menstrual state, pregnancy and hormones. The x-ray appearance of the normal female breast may be classified into four general categories according to maturation:



Figure 5. Normal atrophic breast. Lateral views show replacement of glandular tissue by fat. Blood vessels and fibrous strands remain.

1) Immature breast—This is the type of breast, seen in adolescence, which shows a rather dense, compact mass of fibrous tissue with poorly developed glandular structure and sparse subcutaneous fat.

2) The mature breast—This is the type of breast seen during the childbearing age and exhibits well-developed glandular tissue and varying amounts of supporting fibrous and fatty elements (Figure 4). This breast is predominantly glandular during pregnancy and lactation.

3) The involutional breast—This is the breast seen after the menopause and shows a marked decrease of glandular elements.

4) The atrophic breast—This is the breast of the elderly female with greatly reduced endocrine stimulation and shows replacement of most of the fibrous and glandular tissue by fat (Figure 5).

X-Ray Criteria of Breast Malignancy

The main signs of a malignant nodule on a breast radiograph are as follows:

1) The malignant nodule presents itself as a definite nodular density which is considerably denser than the surrounding normal tissue (Figure 1). In a breast with much fatty replacement the nodule is usually very obvious and very small tumors down to 0.5 cms. in diameter have been detected. In younger women with normally dense breasts small carcinomas are more difficult to recognize.

2) The malignant nodule has an ill-defined margin, from which radiate spicules and tentacles (Figure 1). These tend to cut across the lines of the normal breast trabeculae composed

of ducts and their supporting connective tissue. A benign nodule such as a cyst or fibroadenoma shows a completely smooth and well-defined margin.

3) The malignant nodule will generally appear smaller on the x-ray film than one is led to believe from its size on palpation. This may be due to induration from congestion and edema about the tumor which is not obvious on the x-ray film.

4) A malignant nodule may show typical calcifications. These are usually tiny, dot-like or somewhat elongated, innumerable, and closely grouped together, resembling grains of salt. These calcifications are so small that they are easily missed on a slightly underexposed film. Even a few minute calcifications of this type may signal a carcinoma. Thirty percent of malignant nodules were calcified in one series.[10] Benign calcifications are generally coarser, fewer in number or single and may be due to fatty degeneration, traumatic fat necrosis, secretory disease, degeneration of a fibroid adenoma, and calcified arteriosclerotic vessels and phleboliths.

5) Secondary signs of carcinoma are seen on the breast radiograph as retraction of the nipple, thickening of the skin, and increased vascularity as shown by enlarged tortuous vessels surrounding the tumor.

Benign Breast Disease

Soft tissue radiographs of the breast may be helpful in the recognition of many benign and precancerous diseases of the breast such as adenosis, mazoplasia fibrosa and cystica (Figure 6), fibroid adenoma, plasma cell mastitis, inflamed cysts and intraductal hyperplasia and papilloma. Each of these conditions or a combination of several of these lesions may be recognized by the sufficiently experienced radiologist. Ingleby and Gershon-Cohen feel that breast radiography has aided greatly in the elucidation of the pathology of the breast dysplasias.[11]

The Male Breast

Breast roentgenography has also been applied to the male breast. Forman has examined the breast of 125 men with various symptoms and signs of breast disease.[12] Although the abnormalities of the male breast resemble radiologically those found in the female breast, there is much greater preponderance of simple gynecomastia. Six percent of the total number of cases were proved to have cancer, but only a few of these showed the well known picture of a spiculated dense nodule with fine calcific deposits found in 30% of malignancies of the female breast.



Figure 6. Breast dysplasia (mazoplasia). Thirty-four year old woman with tender, diffusely nodular breasts. Mammogram shows dense parenchyma except for few fatty areas.

Experience at the University of Kentucky Medical Center

Since shortly after the opening of the Department of Radiology about one year ago, we have made an effort to radiograph the breasts of most patients with signs and symptoms of breast disease, particularly those who are to undergo a breast biopsy or mastectomy. We are able to recognize on the x-ray film not only carcinomatous nodules, but also fibroadenomas and cysts as well as various types of breast dysplasias. However, our case material to date has been too small in comparison with other series to present a meaningful statistical analysis of our cases.

Just prior to each mammography we obtain

from the patient a history of present and previous breast symptoms, breast surgery, menses, pregnancy, hormone therapy, thyroid abnormalities, and family incidence of breast and pelvic tumors. This is recorded on a standard form. The radiologist usually examines the breasts and marks the location of breast masses either on a diagram or by affixing a tiny piece of lead to the skin over a palpable nodule. We feel that a personal knowledge of the breast history and the physical findings has improved the accuracy of our interpretation of the radiographs.

Conclusions

The subject of soft tissue roentgenography of the breast has been briefly reviewed. Our experience agrees with the findings of other investigators that mammography is of definite aid in the diagnosis, treatment and follow-up of benign and malignant conditions of the breast. Its greater application in the management of breast disease is recommended.

References

1. Leborgne, R.: Diagnosis of Tumors of the Breast by Simple Roentgenography: Calcification in Carcinoma, Am. J. Roentgenol. 65:1, January 1951.

2. Gershon-Cohen, J. and Ingleby, H.: Carcinoma of the Breast: Roentgenographic Technique and Diagnostic Criteria, Radiology 60:68, January 1953.

3. Egan, R. L.: Experience with Mammography in a Tumor Institution: Evaluation of 1,000 Studies, Radiology 75:894, December 1960.

4. Egan, R. L.: Mammography, an Aid to Diagnois of Breast Carcinoma, J.A.M.A. 182:839, November 24, 1962.

5. Egan, R. L.: Fifty-three Cases of Carcinoma of the Breast, Occult Until Mammography, Am. J. Roentgenol. Rad. Therapy and Nuclear Medicine 88:1095, December 1962.

6. Martin, J. E.; Keegan, J. M.; Lemak, L. L. and Yates, C. W.: Clinically Unsuspected Carcinoma of the Breast, Am. J. Roentgenol. Rad. Therapy and Nuclear Medicine 88:1102, December 1962.

7. Shimkin, M.B.: Cancer of the Breast: Some Old Facts and New Prospectives, J.A.M.A. 183:146, February 2, 1963.

8. Byrne, R.N.; Bringhurst, L. S. and Gershon-Cohen, J.: Postoperative Detection of Cancer by Periodic Mammography of Remaining Breast, Surg., Gynec. and Obst. 115:282, September 1962.

9. Ries, E: Diagnostic Lipiodol Injection in Milk Ducts Followed by Abscess Formation, Am. J. Obst. and Gynec. 20:414, 1930.

10. Gershon-Cohen, J.; Yiu, L. S., and Berger, S.M.: The Diagnostic Importance of Calcareous Patterns in Roentgenography of Breast Cancer, Am. J. Roentgenol. Rad. Therapy and Nuclear Medicine 88:1117, December 1962.

11. Ingleby, H. and Gershon-Cohen, J.: Comparative Anatomy, Pathology and Roentgenology of the Breast, University of Pennsylvania Press, Philadelphia, 1960.

12. Forman, M.: Roentgenography of the Male Breast, Am. J. Roentgenol. Rad. Therapy and Nuclear Medicine 88:1126, December 1962.

Be Sure to Attend

the

KSMA Interim Meeting

at

Jenny Wiley State Park

April 23, 1964 **Prestonsburg, Ky.**

Early Treatment of Pulmonary Abscess*

W. Porter Mayo, Jr., M.D.
Lexington, Ky.

To state our position as simply as possible concerning the whole concept of timing, it may be said that surgery in selected instances is an integral part of early treatment if judiciously used.

IT is my purpose to discuss pulmonary abscess as related to necrosis within a primary pneumonic process; and to elaborate upon our method of surgical management. Excluded are abscesses associated with primary or metastatic cancer of the lung, infected lung cysts, penetrating chest wounds, pulmonary tuberculosis and those due to septic emboli. Our approach may be considered aggressive in relation to timing; however, our efforts have been uniformly successful.

There has been a change in the therapy of pulmonary abscess during the past two decades. Until about 1940, the majority of cases required some type of surgical treatment. Several series reported through the 1950's have demonstrated a mortality of five to thirty-three percent. The latter figure is a regression to pre-antibiotic days and probably due to the rising incidence of Staphylococcus aureus as an etiologic agent. With the advent of antibiotics, the likelihood of cure was increased.

Usual Therapy

On the basis of present day experience, all cases of early acute pulmonary abscess should be treated medically. X-ray studies are made at intervals; and as long as resolution of the inflammatory process continues and the size of the cavity diminishes, the medical program is maintained. Medical therapy should be given to the patient with an uncomplicated case to the point where no further improvement is considered probable. When carcinoma is suspected or surgical complications exist, surgery is advised.

The right lung is more commonly involved than the left. The upper lobes are most often affected. The posterior segment of the upper lobes and the superior dorsal segment of the lower lobes are by far the most commonly involved. Segments such as the right middle lobe and the lingular segment whose bronchi diverge anteriorly from the bronchial tree are rarely involved.

A resume of the usual medical management includes the standardized medical measures of bed rest, diet, ancillary care and transfusions which need no further elaboration.

Postural drainage is a splendid means of gravitational drainage. It has been said, however, that postural drainage is frequently prescribed but seldom used. Aerosol trypsin as a means of promoting drainage may be beneficial.

The proper use of antibiotics is essential to the effective management of pulmonary abscess. Identification of the offending organism at the onset of therapy and the employment of an antibiotic to which the organism is sensitive is vital. After sputum specimens have been collected for culture, an antimicrobial agent is initiated. Penicillin is the most effective antibiotic in almost all cases of lung abscess. It is preferable to start patients on penicillin alone with broad-spectrum antibiotics added as circumstances indicate. Subsequent antibiotic therapy is dictated by the clinical response and the results of bacteriologic determinations including sensitivity studies. The most commonly identified organisms are Staphylococcus aureus and Streptococcus hemolyticus. Staphylococci predominate in children and Streptococci in the adult group.

Bronchoscopy is indicated at least once in every case of abscess. Its purpose is to rule out neoplasm in the older age groups and foreign body, particularly in children, as well as for the therapeutic value. Aspiration of impacted

*Presented at the 1963 Annual Meeting of the Kentucky Surgical Society held May 17-18 in Lexington.

secretions with associated forceful coughing following bronchoscopy often results in prompt evacuation of filled cavities, contributing to more rapid resolution of the acute inflammatory reaction. We have no hesitation in using bronchoscopy daily if necessary. It should be emphasized that patients are not too sick for bronchoscopy.

Bronchography is a very useful means of defining a residual cavitary lesion or bronchiectatic segments requiring surgical excision.

The time factor in surgical intervention is of the utmost importance. When progress has become arrested or residual cavitation after resolution of the acute inflammatory process occurs, resection is indicated. Of even greater importance are those instances in which empyema develops from the abscess. Immediate thoracotomy with resection and/or decortication is indicated. With this accomplished, the disease is not only brought under control, it is eliminated. This is particularly true in infants and children.

The following chart is a concise breakdown of our cases from 1956 through 1962.

Lung Abscess
1956 - 1962

Number of Cases:	24
Male	15
Female	9
Site of Abscess:	
Right upper lobe	14
Left lower lobe	10
Medically treated	15
Surgically treated	9
Mortality	0

Summary

To state our position as simply as possible concerning the whole concept of timing, it may be said that surgery in selected instances is an integral part of early treatment if judiciously used.

References

1. Moore, T. C., Battersby, J. S., Pulmonary Abscess in Infancy and Childhood: Report of 18 Cases, Annals of Surgery, Vol. 151, No. 4, pp. 496-500, April 1960.

2. Pickar, D. N., Ruoff, W. F., Pulmonary Abscess: A Study of 70 Cases, The Journal of Thoracic Surgery, Vol. 37, No. 4, pp. 452-459, April 1959.

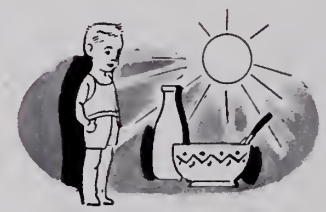
3. Schweppe, H. I., Knowles, J. H., Kane, L., Lung Abscess, The New England Journal of Medicine, Vol. 265, No. 21, pp. 1039-1044, Nov. 23, 1961.

4. Fox, J. R., Hughes, F. A. Jr., Sutliff, W. D., Nonspecific Lung Abscess: Experience with Fifty-Five Consecutive Cases, The Journal of Thoracic and Cardiovascular Surgery, Vol. 27, pp. 255-260, January 1954.

5. Anderson, M. N., McDonald, K. E., Prognostic Factors and Results of Treatment In Pyogenic Pulmonary Abscess, The Journal of Thoracic and Cardiovascular Surgery, Vol. 39, pp. 573-578, January 1960.

6. Lindskog, Liebow, Glenn, Thoracic and Cardiovascular Surgery with Related Pathology, Chapter 7, pp. 155-175, Appleton-Century-Crofts, New York, 1962.

7. Wolcott, M. W., Coury, O. H., Baum, G. L., Changing Concepts in the Therapy of Lung Abscess: A Twenty Year Survey, Diseases of the Chest, Vol. 40, No. 1, pp. 1-4, July 1961.



CASE DISCUSSIONS
From The
University of Kentucky Hospitals

University of Kentucky Medical Center

The Role of Surgery in Carcinoma of the Uterine Cervix

Ben Eiseman, M.D., L. Norton, M.D., and Phillip Crossen, M.D.*

THE majority of women with carcinoma of the uterine cervix are best treated by radiation therapy. Certain of these patients, however, require surgery. It is the purpose of this paper to describe the role of surgery in the treatment of carcinoma of the cervix and to define the procedures thus employed. Such a review is pertinent because of the changing role of surgery in cervical cancer, particularly as it is indicated in more advanced stages of this disease.

Part I—Carcinoma in Situ

Increasing use of cervico-vaginal (Papanicolaou) smear reveals a higher percentage of patients with cervical malignancy confined to the squamous epithelial lining of the cervix. This lesion is known as intraepithelial carcinoma or carcinoma in situ. Whether this non-invasive lesion can in truth be called cancer is a matter of definition, and is of no clinical importance since it is well established that the lesion invariably precedes true invasive cancer of the cervix. Proper surgical treatment of this premalignant lesion should offer a 100% cure. [1, 3]

The Papanicolaou smear[1] is only a screening test and must not be used as the basis for definitive treatment. A. wide circular biopsy (shallow cold knife conization) should be taken after the report of any positive, or persistently suspicious smear in order to determine, 1) if a malignancy is indeed present, and 2) whether or not there is invasion of the stroma underlying the epithelium.

If the malignant process is confined to the epithelium and the patient has completed her family, total hysterectomy should be performed.[2] This is a young group of patients (majority age 25-35 years) and the ovaries should unequivocally be preserved. A one-half to one inch cuff of vagina around the cervix should be removed due to the frequent extension of the malignant process in fingers onto the upper vagina.

In the patient with carcinoma in situ who does not feel that her family is completed, the treatment must be individualized, weighing the risks of further tumor extension against the expectancy of further child bearing. Watchful waiting is frequently indicated inasmuch as it may require as long as 15 years for the preinvasive disease to become invasive. The necessity for close followup and repeated "Pap" smears must be emphasized. Once the family is complete, total hysterectomy should be performed regardless of whether a malignant process is discovered at the time.

Case Report #1

M.B., a 26-year-old lady was found to have a positive Papanicolaou smear on a routine examination one year following birth of her first child. Conization revealed the lesion to be totally excised. She was followed through two more pregnancies during the next four years while Pap smears were taken at four months intervals. She failed to return for examination until three years later when she was found to have an early invasive carcinoma of the cervix. Radiation therapy was thereafter advised.

Part II—Invasive Carcinoma of the Cervix

If the malignant process has extended into the stroma of the cervix, simple hysterectomy no longer is sufficient and radiation is the treatment of choice. In selected good risk cases where the cancer is confined to the cervix and the lesion is less than 1 cm. in diameter (League of Nations Stage I-a or Schmitz 1),[3] surgery in the form of the Wertheim operation is indicated. This procedure[4] consists of radical hysterectomy with removal of the external iliac, hypogastric, and femoral lymph nodes. In such selected patients it offers an equal (90%) 5-year cure rate[5] to that of radiation, without the morbidity occasionally associated with roentgen therapy. The Wertheim Procedure carries the inevitable morbidity of any major surgery and must not be undertaken by the unskilled. Unless performed under good circumstances its morbidity far exceeds that from radiation.

Various combinations of radiation and surgery are being explored for various stages of cervical cancer[6],

*From the department of Surgery and the department of Obstetrics and Gynecology, University of Kentucky Medical School. *Aided in part by grants from the Kentucky Division of the American Cancer Society and the Fred Rankin Surgical Fund.*

but at the moment, the exact role of this combined approach is not clear.

Part III—Surgery in Advanced and Recurrent Cancer of the Cervix

Until a few years ago, little could be done to help the unfortunate women whose cervical carcinoma had spread to involve the rectum or bladder or where such extension appeared following irradiation. During the past decade, it has become clear that both reasonable palliation and a significant percentage of cures can be achieved in these patients by extensive resection of the pelvic viscera. Bricker[7, 8, 9] and Brunschwig[10, 11] have largely been instrumental in developing the indications, benefits and limitations of these techniques in advanced stages of cervical cancer.

The procedure consists in brief of removing the entire uterus and vagina en bloc with the involved urinary bladder, rectum and adjacent lymph nodes. The ureters are implanted into an ileal conduit for urinary drainage and a colostomy performed.[7]

Indications for Pelvic Evisceration

In general, pelvic evisceration is indicated when cervical cancer has invaded pelvic organs but has neither extended into bone nor above the pelvic brim.

A. *Ureteral Block:* Immediately adjacent to the cervix lies the bladder trigone and the ureters. Extension of cervical tumor may therefore frequently result in ureteral obstruction even at a relatively early stage of tumor growth. Usually such a patient will be seen with partial obstruction of one or both ureters, with recurrent attacks of pyelonephritis and hydronephrosis. Untreated, the tumor will soon occlude both ureters. In the fact of a threatened complete urinary obstruction urinary diversion by surgical means occasionally must be done on a semi-emergent basis to prevent renal shutdown.

Case #2

O.B., a 39-year-old housewife, had a stage IV carcinoma of the cervix extending to the pelvic walls bilaterally. Intravenous phelogrophy revealed non function of the right kidney and partial obstruction of the left ureter with moderate hydronephrosis. Barium enema revealed fixation and narrowing of the sigmoid colon and cystoscopy invasion of the base of the bladder by carcinoma. It was elected to complete a full course of external irradiation without urinary diversion. The patient was discharged with a slightly elevated BUN. She was readmitted to the hospital in severe uremia after one month and expired within a few hours thereafter.

In this case radiation therapy was inadequate in altering the obstructive features of cervical carcinoma once it had begun to encroach on the ureteral orifices.

Faced with impending complete urinary track blockade by cervical cancer, either a ureterostomy or an ileal bladder can be constructed to obtain immediate relief. If there is any possibility of excising the tumor, an ileal bladder is to be preferred, either in combination with pelvic evisceration or as a preliminary stage to exenteration. If staged, the patient's general condition can be improved, the effect of radiation therapy be given further trial, or more careful evaluation of tumor resectability studied. The following case illustrates the occasional value of such staging.

Case #3

E.M., a 25-year-old mother of five, was admitted to University Hospital in the fifth month of pregnancy with advanced carcinoma of the cervix. Abdominal hysterotomy for therapeutic abortion was performed immediately. Intravenous pyelography revealed no evidence of dye excretion on the left and cystoscopy showed bullous edema of the bladder. Cobalt therapy was begun on the sixth day following hysterotomy but was briefly interrupted five days later when the patient was readmitted to the hospital for surgical urinary diversion by means of an ileal-conduit. The patient subsequently received irradiation totalling 5,500 roentgen with regression of the tumor mass. The patient was hospitalized four months after urinary diversion for pelvic exenteration with sparing of the rectum.

B. *Post-Irradiation Recurrency:* A distressing number of patients have recurrence of cervical carcinoma following even the best of radiation therapy. Previously such women were doomed. It is now clearly evident that in selected cases radical excisional therapy can completely remove the recurrent tumor. The physician in general practice, the radiotherapist and the gynecologist must be aware of the benefits and limitations of surgery in such patients with post-irradiation recurrence.

When cervical carcinoma recurs following irradiation, the tumor and its surrounding radiation reaction may involve either the adjacent bladder or rectum. It is women with post-irradiation recurrence that form the majority of patients in whom pelvic evisceration is indicated.

C. *Post-Irradiation Fibrosis:* Radiotherapy under ideal circumstances does not result in disabling fibrosis. Unfortunately however, irradiation may occasionally produce unbearable cystitis or proctitis. Pelvic evisceration rather than a neurosurgical procedure has on occasion been required for palliation under such circumstances.

D. *Recurrence Involving the Uterus and Bladder Alone:* Recurrence following radiotherapy usually will involve both the bladder and the rectum and total removal of each organ with the cervix is necessary. On occasion tumor extension will spare the rectum. Careful preoperative evaluation of both the bladder and rectum by pelvic examination, cystoscopy and sigmoidoscopy must be done on every patient to detect preoperatively any possibility of such limited tumor extension. At operation the surgeon often may be confused between reaction due to irradiation and tumor growth.

The following case illustrates such a case where tumor did not extend into the rectum which could be spared and later utilized for re-establishing normal fecal continuity.

Case #4

M.C., a 22-year-old lady had received 6,000 mgm hours of radium therapy and subsequent X-ray therapy for carcinoma of the cervix. Six months after completion of therapy she was found to have a recurrence of a grade III carcinoma. The bladder and a point high in the rectosigmoid were involved. It was impossible to determine preoperatively whether tumor, radiation reaction, or infection gave the impression of lateral pelvic fixation. At operation no tumor fixation was found and a pelvic exenteration was performed. A six cm. length of rectal stump was saved. All margins of the resected specimen were clear of tumor.

She has continued well for the 20 months since operation and takes care of her housework and her children. It is planned to reanastomose the sigmoid to the rectal stump in the near future.

This case illustrates the difficulty in determining preoperatively the exact boundaries of tumor in the presence of infection and post-irradiation reaction. Frozen section control of the operative boundaries are a necessity under these circumstances. An interval of a year or more should be allowed before fecal continuity is re-established to be assured of freedom from tumor recurrence.

E. *Selection of Candidates for Operation:* The inevitable morbidity and occasional mortality involved in this type of extensive surgery necessitates careful selection for operation. By any standards this is major surgery and involves the usual evaluation of the cardiovascular and pulmonary systems.

Some degree of hydronephrosis is almost routine in these patients but neither it nor moderate uremia is a contraindication to operation. With relief of obstruction by diversion into the ileal segment, renal function characteristically has a gratifying return to normalcy and hydronaphrosis regresses markedly in a majority of the cases.[9]

Evaluation for metastases beyond the confines of the pelvis must be made both prior to and at operation. By history, pain of sciatic distribution usually indicates tumor invasion of the sciatic plexus. Similarly involved inguinal modes or swelling of either leg connotes lymphatic involvement and clearly contraindicates exploration. A preoperative pyelogram showing ureteral obstruction above the brim of the pelvis is unusual but represents tumor extention beyond the confines of operability. Careful roengenologic examination of the chest obviously is required preoperatively to exclude pulmonary metastases.

The prime contraindication to pelvic exenteration is tumor extension into the lateral bony pelvis. This not only requires a most thorough pelvic and rectal examination prior to surgery, but may require a repeat examination under anaesthesia. Frequently it is extremely difficult to settle this point in a patient who has post-irradiation recurrence of cervical tumor or where there is accompanying inflammatory fixation. In the latter category, fixation has often been due to infection, not tumor extension, and the lesion actually found to be resectable.

Case #5

B.E., a 52-year-old lady had a total of 5,000 roentgens of radiation for carcinoma of the cervix. Six months later biopsy of a mass extending laterally to the pelvic walls revealed persistant carcinoma. At operation the bladder and rectum were involved by a mass extending to the pelvic walls but was not fixed peripherally. Pelvic exenteration with urinary diversion by an ileal conduit was performed. Lateral margins of the resection were free of tumor and showed extensive inflammatory reaction, secondary to irradiation. The patient's postoperative course was uncomplicated.

In this case and Case #4, actual tumor mobility was only determined at operation when preoperative examination was unable to differentiate inflammation from neoplastic fixation.

At operation approximately 10% of these patients, despite the most careful screening, will be found to have inoperable lesions either because of fixation to bone, involvement of periaortic nodes, or deposits in the liver.

Recently the gloomy prognosis and poor chance for care now recognized to be associated with tumor involvement of regional lymph nodes has suggested that exenteration for cure is contraindicated if regional lymph nodes along the iliae vessels are involved with tumor.[13]

There is a very limited place for palliative pelvic evisceration. Only occasionally it is the only means of benefit for a woman whose necrotic pelvic tumor has produced a radioresistant foul and offensive cervical discharge or who suffers from recurrent and persistent hemorrhage. If deep pelvic pain alone is associated with such recurrent and unresectable tumor neurosurgical procedures are preferable to exenteration.

Mortality, Morbidity and Results of Pelvic Evisceration

Operative mortality for pelvic evisceration approximates 10%.[9,12] It obviously is not an operation to be performed by the occasional surgeon nor even by the expert except under ideal conditions. The risk is appreciable but it must be recognized that this represents a group of salvage patients who are resistant to all other forms of therapy and are otherwise foredoomed.

The overall cure rate in these patients following pelvic evisceration is 34% in Bricker's series[9] and 19% in a comparable earlier series of Brunschwig.[12]

The price paid for the benefits of pelvic evisceration is extensive and must be thoroughly appreciated by the patient prior to operation. The abnormal postoperative status of fecal and urinary diversion may on first consideration be more repulsive than any possible benefits. This is far from true. The limitations of colostomy are well known. Those of urinary diversion via the ileal conduit superimpose an added burden but the patient remains dry, odor free, and the ileal bag containing urine can be emptied whenever convenient without its removal from the abdominal

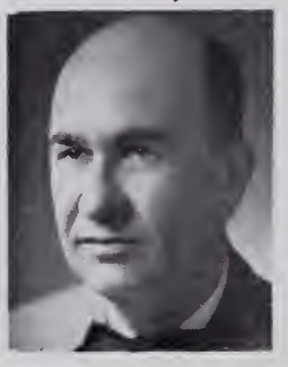
Continued on Page 166

SPECIAL ARTICLES

Kentucky's Medical Care Program Passes Third Successful Birthday

G. L. Simpson, M.D.
Greenville, Ky.

MEDICAL care for Kentucky's needy elderly citizens had its third successful birthday January 1, 1964. This care for the needy was made possible by action of the 1960 Kentucky General Assembly and Governor Bert T. Combs. During the regular session (January, February and March) approximately 55,000 age 65 and over who were receiving food, clothing and shelter under Old Age Assistance (OAA) group of public assistance, were also extended medical care benefits. KSMA and other allied medical groups gave strong support to this program. Federal-State money is on an 80-20 percentage matching basis.



Doctor Simpson

Federal legislation providing medical aid for the aged (MAA) sponsored by the late Senator Rober Kerr and Congressman Wilbur D. Mills, known as Kerr-Mills legislation, became law in September, 1960. The MAA Program was initiated to protect those who can provide for their food, clothing and shelter but might be reduced to perhaps permanent OAA status when subjected to paying for their medical care.

In September 1960 Governor Combs called a special session of the legislature to consider paying the veterans bonus. Since Congress had approved the Kerr-Mills Law, and Kentucky would qualify for 75-25 Federal-State matching, the Governor included MAA in the call. The Bill was overwhelmingly approved by the legislators.

The Department of Economic Security in Frankfort estimates 296,000 people in Kentucky are over 65 years of age (including 55,000 mentioned above) and 87,000 of this number are potentially eligible for MAA benefits. This number is based on an arbitrary annual income figure for a single person or families liquid assets, non-homestead real property and cash surrender value of life insurance policies. Although 87,000 are potentially eligible for participation in this Program, only 22,625 applied for MAA benefits from January 1, 1961 to October 31, 1963. Of this number 2,485 were found not eligible to participate.

Benefits to recipients and vendors participating in the indigent medical care program have increased consistently, yet cautiously and orderly. Members of the Council on Allied Medical Services (composed of the State organizations of dentists, pharmacists, hospitals, nurses and physicians) each have a member on the Governor's Advisory Council and a technical advisory committee. The latter presents the views of its organization to the two State agencies administering the program and recommends changes in the program to better serve its clients.

Presently all program recipients are eligible to receive hospital care for acute, emergency or life-endangering conditions, including maternity care. Ten days per hospital admission are payable by the program. Physicians may receive payment for eighteen office or home visits per recipient per calendar year. Physicians' visits to hospitalized patients are not covered by the program, and such visits may not be considered as home or office visits.

The dentist is paid for extractions and fillings and for treatment involving pain, infection

or hemorrhage. All program beneficiaries may receive drugs dispensed in accordance with the Medical Care Drug List and the policies and procedures for dispensing drugs.

Program recipients pre-authorized to need skilled nursing care are eligible to receive benefits for an indefinite period of time. All licensed nursing homes are eligible to participate on a flat rate basis. Homes meeting high criteria of attainment are eligible to participate on a reimbursable cost basis for 120 days per calendar year.

This program is too limited in scope to please some of us, and there are some of us who believe it is too inclusive. Others do not agree with the philosophy of the program. Consider with me:

1. The MAA Program is locally directed in Kentucky and can be curtailed as need decreases.
2. Our profession participates in its direction.
3. It is not compulsory.
4. It does not dispense care at taxpayers expense except where need is clearly shown.
5. It is a plan designed to alleviate suffering of a group of our citizens who are insolvent.
6. It was not established primarily as a means of income for those rendering services.
7. By active participation in this program we may be able to solve a problem which is thought by others to require a compulsory medical care program in the Social Security Act for its solution.

Could we not approach this matter with the philosophy of the recipient receiving first consideration, the taxpayer second—we are also taxpayers—and the vendors of services thirdly? The program has been accepted by a vast percentage of the Profession. Is it too much to ask all of our membership to fully support this plan? The matter deserves our most earnest and serious consideration at this time.

Plan to attend

KENTUCKY CONGRESS ON MENTAL HEALTH

Kentucky Hotel, Louisville

May 14, 1964



To Save A Life

ON January 1st the Courier-Journal published on its editorial page a list of Kentuckians killed in street and highway accidents during the preceding year in the state. In 1963 eight hundred thirty names were listed —in 1962 there were eight hundred and six. These figures correspond accurately with the records of Kentucky State Police.

To anyone driving on our streets and highways this is not surprising news. From the near misses that one experiences on any trip it seems miraculous that the number of fatalities is not much higher. Nevertheless there is cause for us as physicians to soberly consider what we can do to render motor travel safer. Arthur H. Keeney, M.D., as chairman of the K.S.M.A. Highway Safety Committee, wrote a special article in this Journal in July, 1963 and has been most diligent in bringing to the attention of physicians over the state their responsibility. Horace E. Campbell, M.D., of Denver, addressed the Jefferson County Medical Society in May of 1963 and his remarks are published in the August issue of this Journal.

It has long been established that the use of proper seat belts significantly reduces fatalities and serious injuries resulting from traffic accidents, yet automobile manufacturers have been most reluctant to fit this simple safety measure in new cars as standard equipment or even to install when specifically requested. Moreover physicians have not universally adopted them nor are they always as alert as they should be to endorse and urge their use to those who look to them for health and safety advice.

A bill to provide for universal motor vehicle inspection was presented to the special legislative sessions last fall but failed of passage. All the reasons for its defeat are not very well known but the intent of the measure was sound. It is hoped that the proposal may be presented in a more acceptable form before the present session of the legislature with better hope of its adoption.

The State Health Department for a long time has tried to set up a program for medical examination and review of known accident prone drivers, thus reducing the danger to themselves and the innocent driving public. The Highway Safety Committee of K.S.M.A. and the State Commissioner of Public Safety have cooperated in establishing a Review Board to eliminate dangerous drivers. This has been activated in 1964.

The use of alcohol has always been, and is increasingly, a factor in highway fatalities. The unauthorized use of barbiturates, tranquilizers, and stimulating drugs have played a major role in recent years. It is hard to control the unwise use of any of these agents but the physician, more than anyone else, has some influence and should keep these dangers ever in mind.

One of the most difficult roles a physician is called upon to fill is to decide that a patient, and sometimes a long-time friend, is not a safe driver. It is hard to impress upon such a person that he endangers not only his life and safety but countless others. Specifically, a severe diabetic who may experience periods of hypoglycemia or of approaching acidosis; the cardiac who may have Stokes-Adams attacks; the severe arteriosclerotic or hypertensive in whom periods of fleeting cerebral anemia or "little strokes" have occurred; the recent victim of coronary heart disease; the patient with badly defective vision or hearing; most frequently the aging person who "has never had an accident," but of whom it is apparent to everyone except himself that he is no longer capable of coping with present day traffic: these are problems requiring tact

and kindness but also firmness, for safety's sake. It is a responsibility that we as phyisicians cannot evade.

In the construction of our highways and expressways the best precautions for safety have sometimes not been provided. An approach into the left lane of traffic is rarely seen but, because unexpected, it is an additional hazard especially to drivers unfamiliar with that section of road. Visibility of traffic on some approaches is poor. Some traffic signs are found to be confusing. Upon occasion we may be instrumental in helping to improve the safety of the highway itself.

In 1962 our traffic toll was 806 — in 1963 it was 830. In 1964 it may be even higher. These are needless deaths. We as guardians of life and health can help to reverse this trend.

SAM A. OVERSTREET, M.D.

Senior Day 1964

MARCH 16, 1964, will mark another anniversary date for the KSMA. On this date, the State Association will put on its Tenth Annual Senior Day Program. It is fitting that this should be the first year for this program to be presented also to the University of Kentucky Senior Class.

Meetings of the Senior Day Committee with representatives from both medical schools have produced another program which is calculated to be of benefit to both graduating classes in their transition from student to physician. Much time and effort has been spent securing competent speakers for the several subjects which have been found to be helpful in past years. The entire faculty for this day has been selected and has agreed to participate.

The Senior Day Committee does not want to be guilty of overly emphasizing the importance of this program, because we do not believe that in one short day we can do much to change the philosophy and attitudes of the graduating seniors. However, we do recognize at the same time that this is possibly the last concentrated effort which we will have to demonstrate to these young men and women our interest in them, and our welcoming of them into the medical profession.

Inasmuch as this is a State Association project, I want to extend a special invitation to all those on the Board of Trustees and other positions of responsibility in the KSMA, because I feel that you will be proud of the quality of the program which will be presented. Your committee looks forward with anticipation to presenting the program to the University of Louisville on the 16th of March, 1964, at the Medical Arts Building in Louisville, and to the graduating seniors of the University of Kentucky on a date which has not yet been chosen.

DONALD CHATHAM, M.D.
Chairman, Senior Day
Committee

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

In Kentucky

FEBRUARY

13	Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.
13	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
13-15	Rheumatic Diseases, University of Kentucky, Lexington, Ky.
19	Cancer Teaching Lecture Series, University of Kentucky, Lexington, Ky.
20	Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.
20	University Surgery Day, University of Kentucky, Lexington, Ky.
20	Contributions of Modern Pharmacology to Rational Clinic Use of Drugs, University of Kentucky, Lexington, Ky.
27	Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.
28	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

MARCH

5	Thursday Night Psychiatry Seminar, University of Kentucky, Lexington, Ky.
12	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
12-14	Hematology, University of Kentucky, Lexington, Ky.
19	University Surgery Day, University of Kentucky, Lexington, Ky.
25-26	Kentucky Heart Association, Louisville, Ky.
27	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.
30-April 2	Kentucky Hospital Association, Louisville, Ky.

APRIL

1	9th Annual Clinical Conference, Lexington Clinic, Lexington, Ky. Difficult Problems in Treatment of Peptic Ulcer and A Pilot Study of TB Eradication in Kentucky.
2	Kentucky Industrial Medical Association, Holiday Inn, N.E., Louisville, Ky.
5-8	Kentucky Dental Association, Louisville, Ky.
9	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
14-16	Kentucky Public Health Association, Kentucky Hotel, Louisville, Ky.
16	University Surgery Day, University of Kentucky, Lexington, Ky.
23	KSMA Interim Meeting, Jenny Wiley State Park, Prestonsburg, Ky.
24	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

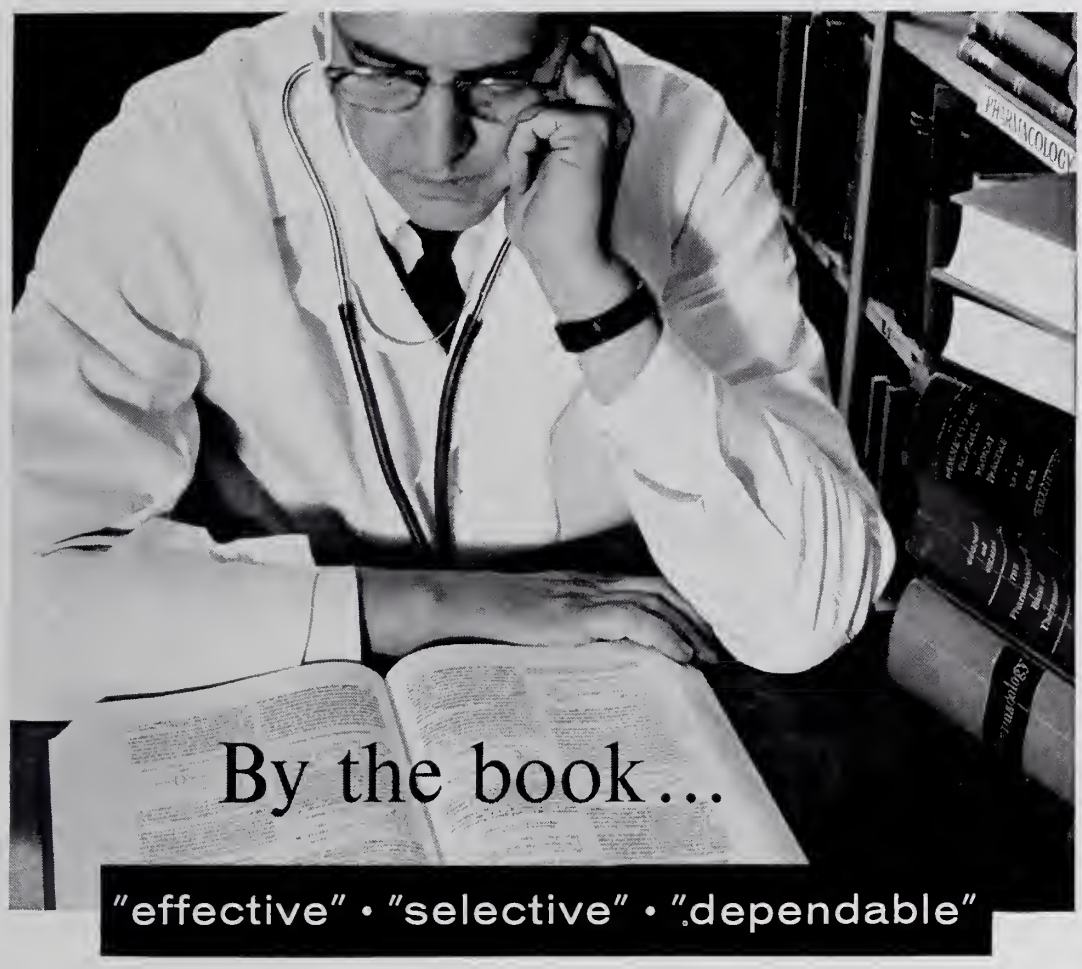
Surrounding States

FEBRUARY

12-16	American College of Cardiology, New Orleans, La.
20	Recent Advances in OB-GYN in General Practice, Ohio State University, Columbus, Ohio
26-27	Recent Advances in Pediatrics, Cleveland Clinic Educational Foundation, Cleveland, Ohio

MARCH

2-3	7th Annual Course in Ophthalmology, Ohio State University, Columbus, Ohio.
2-4	Postgraduate Course in Gynecologic Endocrinology, Michael Reese Hospital and Medical Center, Chicago, Ill.
2-4	Symposium on Fundamental Cancer Research, Houston, Texas.
4-5	Changing Concepts in Gastroenterology, Mercy-Timken Mercy Hospitals, Canton, Ohio.
16-28	Anatomical and Clinical Otolaryngology, Indiana University, Indianapolis, Ind.
18	Clinical Allergy, Ohio State University, Columbus, Ohio.
18-19	Hypertension and Renal Diseases, Cleveland Clinic Educational Foundation, Cleveland, Ohio.
18-19	Obstetrics and Gynecology, Indiana University, Indianapolis, Ind.



PRO-BANTHĪNE®

BRAND OF propantheline bromide

For Ten Years... the Standard Anticholinergic

Many studies by many investigators over many years have established Pro-Banthīne (propantheline bromide) as the standard anticholinergic in the management of peptic ulcer and other gastrointestinal disorders.

It Is Effective—Hundreds of comparative laboratory and clinical trials and innumerable gratified patients have made Pro-Banthīne (propantheline bromide) the most widely-prescribed medication in its class.

It Is Selective—Its major effect is on the gastrointestinal and urogenital tracts. Secondary activity when noticeable seldom passes the point of temporary annoyance.

It Is Dependable—Moderate doses reduce gastric secretion and acidity and diminish gastrointestinal hypermotility. The usual dosage may be safely doubled or tripled to suppress symptoms in patients with severe or refractory conditions.

These qualities have won such wide recognition in standard texts on pharmacology and therapeutics that to prescribe Pro-Banthīne (propantheline bromide) is truly to prescribe "by the book."

The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime.

Side Effects And Cautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur with Pro-Banthīne (propantheline bromide). It is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthīne (propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

G. D. SEARLE & CO.
CHICAGO, ILLINOIS 60680
Research in the Service of Medicine

ORGANIZATION SECTION

Problems of Current Interest to be Analyzed for Kentucky Physicians By Top Guest Speakers at 1964 KSMA Interim Meeting



Doctor Hanley



Doctor Hall

Five top-ranking authorities on socio-economic medical issues will present a program of great interest to those attending the 14th Annual Interim Meeting at Jenny Wiley State Park, Prestonsburg, on Thursday, April 23.

George P. Archer, M.D., KSMA president, underlined the significance of the session, the second most important sponsored by KSMA each year, and urged all KSMA members to attend this essential meeting. Doctor Archer recently released the following partial list of guest speakers and their topics.

Durward G. Hall, M.D., Springfield, Mo., who is currently serving his second term in the U.S. House of Representatives, will address the meeting on "Fedicare and Politics". Doctor Hall, a Republican and a general surgeon, is a member of the House Armed Services Committee. He is a 1934 graduate of Rush Medical School in Chicago and a decorated veteran of World War II. Among his many current medical and civic activities, Doctor Hall is a Delegate to the American Medical Association, a member of the Drury College Board of Trustees, and vice-president of Region 8, Boy Scouts of America. He has held additional important posts in the past.



Mr. Walker

"The Physician and Health Insurance" will be the topic of Daniel F. Hanley, M.D., Brunswick, Me., executive director of the Maine Medical Association and editor of The Journal of the MMA. Doctor Hanley, an orthopedic surgeon, is a graduate of Columbia University College of Physicians and Surgeons. He is a member of the Advisory Committee to the Department of Health, Education, and Welfare, and a former member of the Board of Directors of the Maine Blue Cross-Blue Shield. He is a member of the American Academy of General Practice, the



MOUNTAIN SETTING—Jenny Wiley State Park Lodge, pictured above, will be the site of the 1964 KSMA Interim Meeting. The park, located near Prestonsburg, is well-known for its excellent meeting facilities, as well as for the beauty of its surroundings.

American College Health Association, and the American Medical Writers Association.

Clarence N. Walker, L.L.B., Atlanta, Ga., Executive Staff Representative of the Coca-Cola Company and popular lecturer, will be the luncheon speaker at the April 23 session. Mr. Walker will speak to KSMA members and their guests on "Keys to Success and Happiness." A native Georgian, Mr. Walker practiced law in Georgia and North Carolina for six years. He has served in the communities of Ashville, N. Car., and Atlanta and Rome, Ga., in various business, civic, and professional capacities. He is a member of the Baptist Church, a Mason, Shriner, and Rotarian. He is past president of both the Ashville and Rome Rotary Clubs.

In releasing the above information, Doctor Annis emphasized once more that not only is Jenny Wiley Park easily accessable from any part of the state, but that adequate lodging will be available for all who plan to attend.

Dr. Denham Elected Head of Ky. House Majority

Mitchel B. Denham, M.D., Maysville general practitioner who is serving his third term in the Kenutcky House of Representatives, was elected Majority Leader of the House on January 9. It was reported that Doctor Denham was supported by Governor Edward T. Breathitt.



Doctor Denham

Doctor Denham, a Democrat and a past recipient of KSMA's Distinguished Service Medal, has been active in KSMA and KAGP. He is a member of the KSMA Board of Trustees and has been a member of the KSMA Council on Legislative Activities, as well as serving in Legislative Committee work.

As Majority Leader of the house, his duties are primarily to guide the Administration's program through the House of Representatives. He handles all of the Administration's bills, but in the last 15 days of the session, when the Rules Committee takes over, he is chairman. During this time no measure can be considered except on his motion.

Dr. Loveman on Program

A. B. Loveman, M.D., Louisville dermatologist, appeared as a guest speaker on the scientific program of the 28th annual meeting of the International Medical Assembly of Southwest Texas held January 30-February 1 in San Antonio, Tex. Doctor Loveman, who is chief of the section of Dermatology and Syphilogy at the University of Louisville, addressed the assembly on "Cutaneous Disorders of the Female Genitalia", "Common Disorders of the Face and Scalp", and "Mucous Membrane Lesions of Interest to the General Practitioner".



Dr. Van Meter



Dr. Higdon

Board of Health Elects Dr. Higdon President

O. L. Higdon, M.D., Paducah, was elected president of the Kentucky State Board of Health on January 9, to succeed E. M. Howard, M.D., Harlan, who had held the position for 35 years until his retirement in October.

Doctor Higdon, who has been active at the County Society and State Association levels, and a member of the KSMA Board of Trustees, has been on the Board for two years.

J. Ferra VanMeter, M.D., Lexington, a past chairman of the KSMA Council (now Board of Trustees), was appointed to serve on the State Board of Health by Governor Edward T. Breathitt on January 15. Doctor VanMeter succeeds Carl H. Fortune, M.D., Lexington, who was not eligible to succeed himself.

Doctor VanMeter has long been active in church, civic, and medical organizational affairs in Lexington. He is past president of the Kentucky Chapter of the American Cancer Society.

Okla. M.D.s Hear Dr. Gardner

Oklahoma physicians, attending their County Officers Conference January 25 in Oklahoma City, heard how Kentucky physicians were able to win the top award for 1963 offered by the American Medical Political Action Committee during the AMA meeting in Portland, Ore.

Hoyt D. Gardner, M.D., Louisville, chairman of the Board of Directors of the Kentucky Educational Medical Political Action Committee, gave the "Kentucky Story". Doctor Gardner's appearance was sponsored by AMPAC during a symposium presented by the Oklahoma Medical Political Action Committee at the conference.

Ky. Ob-Gyn Society to Meet

Lawrence L. Hester, Jr., M.D., professor and chairman of the department of Obstetrics and Gynecology at the Medical College of South Carolina at Charleston, will address the members of the Kentucky Obstetrical and Gynecologic Society at the annual meeting of the Society at Stouffer's Louisville Inn May 7-9. A complete program of the meeting will appear in a later issue of The Journal.



Gathered in Louisville for the KSMA dinner honoring Edward R. Annis, M.D. on January 7 were members of the Association's Executive Committee. From left to right, standing, are: Mitchel B. Denham, M.D., Maysville, Trustee; Dixie Snider, M.D., Springfield, trustee; Henry B. Asman, M.D., Louisville, KSMA secretary; and Douglas E. Scott, M.D., Lexington, chairman of the Board of Trustees. Seated are George P. Archer, M.D., left, Prestonsburg, KSMA president; Doctor Annis; and Delmas M. Clardy, M.D., Hopkinsville, president-elect. Gabe A. Payne, M.D., Hopkinsville, vice-chairman of the Board of Trustees, was not present when the photo was taken.



Edward R. Annis, M.D., AMA president, bottom row, center, is shown with KSMA delegates and alternate delegates to the AMA at the dinner given for Doctor Annis by KSMA on January 7 in Louisville. Pictured are: top row, from left, Charles G. Bryant, M.D., Louisville, alternate; Wyatt Norvell, M.D., senior delegate, New Castle; and Charles C. Rutledge, M.D., Hazard, alternate. Seated are J. Thomas Gianinni, M.D., left, Louisville, delegate; Doctor Annis; and John C. Quertermous, M.D., Murray, delegate. Missing from the photo was William W. Hall, M.D., Owensboro, alternate.

Ky. General Assembly Hears Talk By Dr. Annis on Kerr-Mills

Edward R. Annis, M.D., Miami, Fla., president of the American Medical Association, praised Kentucky's Kerr-Mills program in an address before the joint session of the Kentucky Legislature at Frankfort on January 8. Doctor Annis also discussed the relationship between cigarette-smoking and cancer.

The speech was the high point of a three-day whirlwind tour of the state made by the AMA chief executive. Invited to Kentucky to address the General Assembly, Doctor Annis managed to work in a number of talks with various medical groups during his visit.

Shortly after arriving in Louisville on Tuesday, January 7, Doctor Annis spent some time in recreation in the form of a game of tennis at St. Agnes School with Everett H. Baker, M.D., Frank Radmacher, M.D., and Robert Tate, M.D., all of Louisville.

Following the afternoon game, he was the guest of Phyllis Knight on her regular WHAS television program, Small Talk. Miss Knight and the AMA head discussed quackery in medicine.

A dinner the same evening at the Holiday Inn SE gave officers of KSMA and the Jefferson County Medical Society, as well as members of the KSMA

Council on Legislative Activities and the Board of Directors of KEMPAC, the opportunity to hear Doctor Annis speak on medical-political problems now facing the profession.

Seventy-six people representing 40 allied areas of interest attended the Wednesday morning country-ham breakfast given in Doctor Annis' honor by the Jefferson County Medical Society. At 10 a.m. the same morning he addressed the students and faculty of the University of Louisville School of Medicine.

Following the U. of L. session, he proceeded to Frankfort for his address to the legislature. That afternoon Doctor Annis was entertained at the home of B. F. Baughman, M.D., in Frankfort, for a social hour before attending a dinner given in his honor by the Kentucky physicians who formed the Committee of 100 for Breathitt-Waterfield during the recent gubernatorial campaign. Governor Breathitt, members of the committee and their wives, and a limited number of guests, heard Doctor Annis speak on "Doctors and Their Wives in Politics".

A speech before the faculty and students of the University of Kentucky College of Medicine on Thursday morning, January 9, ended the AMA executive's visit to the Commonwealth.

George S. Beard, M.D., recently opened an office in Hartford for the practice of general surgery. Doctor Beard, who graduated in 1956 from The University of Louisville School of Medicine, interned at the Receiving Hospital in Detroit, and completed his residency training in Detroit and Dearborn, Mich., hospitals. He previously practiced at Jacksonville and Virginia, Il.



Edward R. Annis, M.D., center, president of the American Medical Association, was the guest of honor and speaker at a dinner given by KSMA at the Holiday Inn in Louisville during his Kentucky visit. Pictured with Doctor Annis are Hoyt D. Gardner, M.D., Louisville, left, chairman of the Board of Directors of KEMPAC, and John C. Quertermous, M.D., Murray, AMA delegate from KSMA and chairman of the Council on Legislative Activities for National Affairs.



Kentucky Governor Edward T. Breathitt, center, confers with Edward R. Annis, M.D., Miami, Fla., left, AMA president, and Gabe A. Payne, M.D., Hopkinsville, vice chairman of the KSMA Board of Trustees, following a dinner given in Frankfort in honor of Doctor Annis. Doctor Payne was also chairman of the Doctor's Committee of 100 for Breathitt-Waterfield, who sponsored the dinner.

Members Urged to Support State and Local C. of C.

You, as a member of KSMA, are urged to join, actively participate in, and support your local and state Chambers of Commerce.

This is the recommendation of both the KSMA House of Delegates in Lexington at the 1963 Annual Meeting, and of the AMA House of Delegates taken at Portland, Oregon, in December of 1963.

The KSMA resolution pointed out that Chambers of Commerce "depend upon and need the talents and resources of the businessmen and professional men dedicated to the improvement of the free-enterprise system." G. L. Simpson, M.D., Greenville, 1961-62 KSMA president, is a member of the Board of Directors of the Kentucky Chamber of Commerce.

Board Asks County Societies To Hear Delegates Speak

Because of the wealth of material on the operation of organized medicine acquired by the delegates and alternate delegates to the AMA, members of the KSMA Board of Trustees urged that this information be made available to more of our members at the local level.

The Board voted to explain to county medical societies that this material would be of great value to their members, and to suggest that the county societies call upon KSMA delegates or alternates to provide a program in whole or part for their societies.

The Board also voted to ask delegates and alternates of KSMA to accept all invitations to speak.



COUNTRY HAM FEAST—The Jefferson County Medical Society entertained with a country ham breakfast on January 8 in honor of Edward R. Annis, M.D., visiting AMA president. Among the guests were some 40 business and professional people from Louisville. Seated at the head table, from left to right, are: Walter I. Hume, Jr., M.D., Louisville; George P. Archer, M.D., Prestonsburg, KSMA president; William P. Vonder Haar, M.D., Louisville; Robert W. Lykins, M.D., Louisville; Doctor Annis; Thomas Giannini, M.D., Louisville; and C. Melvin Bernhard, M.D., Louisville.

Fees to be Charged for Hospital Surveys

The following statement was taken from the *Bulletin* of the Joint Commission on Accreditation of Hospitals.

"January 1, 1964, and thereafter until further notice, there will be a charge for hospital surveys. The charge will be $60 per hospital, plus $1 per bed (exclusive of bassinets) up to 250 beds. This means that the smallest eligible hospital of 25 beds will pay $60 plus $25, or a total cost of $85. A hospital of 250 beds or more will pay $60 plus $250, or a total cost of $310. The administrative cost of the program of the Joint Commission will continue to be paid by the member organizations. The bed capacity of a hospital will be ascertained from the most current issue of the Guide Issue, Part Two, of HOSPITALS, A.H.A.

One month prior to the impending survey, the hospital will be notified of the date of survey and an invoice will be included to cover the cost of the survey to that specific hospital, with a request that it be paid immediately or some time prior to the survey. Whether or not payment has been received, the survey will be made. It is of no concern to the surveyor whether or not payment has been made, and under no circumstances is he to accept the survey charge fee.

After the survey has been completed and the report prepared, the hospital will not be sent its report until payment is received at the Commission. If, after proper notification by the Commission, payment is not received by year end, the hospital will be considered non-accredited and will not be listed in the annual published list of Accredited Hospitals."

Lexington Clinic Conference Scheduled for April 1

The Annual Clinical Conference sponsored by the Lexington Clinic and the Kentucky Academy of General Practice, previously held in the fall, has been set instead for April 1 this year, according to C. Richard Gill, M.D., Lexington, conference committee chairman.

"Difficult Problems in the Treatment of Peptic Ulcer" will be the topic of the morning session panel discussion. John P. Utz, M.D., chief of Infectious Disease Service of the National Institute of Allergy and Infectious Diseases, will be the guest speaker that morning.

Kurt Deuschle, M.D., chairman of the department of Community Medicine, at the University of Kentucky, will address the afternoon session on "A Pilot Study of TB Eradication in Kentucky". In addition, an interesting and informative program will be presented by members of the Lexington Clinic staff.

Surgical Society to Meet In May

Kenneth Warren, M.D., of the Lahey Clinic in Boston, Mass., will be the featured guest speaker at the annual meeting of the Kentucky Surgical Society to be held this year at Vanderbilt University Hospital in Nashville May 15 and 16. A later issue of The Journal will carry a full program.

Dr. Ling Heads Radiologists

J. T. Ling, M.D., professor and chairman of the department of Radiology at the University of Louisville School of Medicine, was installed as 1964 president of the Kentucky Radiological Society at the January 10 meeting at the Sheraton-Seelbach Hotel in Louisville. Joan Hale, M.D., Louisville, was installed as secretary.



ACHROCIDIN®

TETRACYCLINE HCl-ANTIHISTAMINE-ANALGESIC COMPOUND

Each Tablet contains:

ACHROMYCIN® Tetracycline HCl	125 mg.	Caffeine	30 mg.
Acetophenetidin (Phenacetin)	120 mg.	Salicylamide	150 mg.
		Chlorothen Citrate	25 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms, tooth discoloration. The last named may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Average Adult Dosage: 2 Tablets four times daily.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

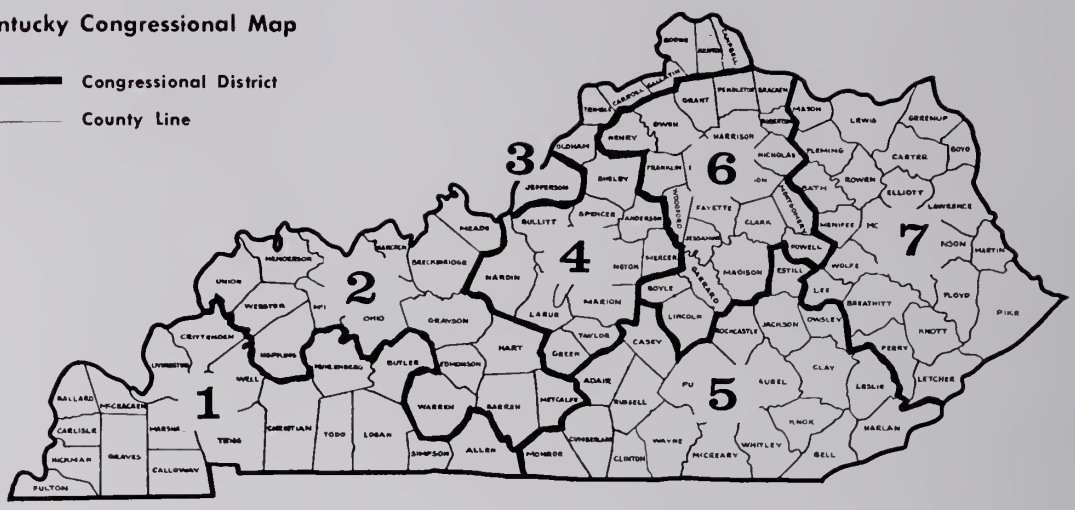
Lederle

7144-3

Kentucky Congressional Map

Congressional District

County Line



How to Reach Your Congressman On Current Health Matters

KSMA members are becoming increasingly interested in legislation relating to health matters in the Congress. This is very much in the public interest, said John C. Quertermous, M.D., Murray, chairman of the KSMA Council on Legislative Activities for National Affairs.

In order to facilitate your communications with your congressman, Doctor Quertermous has requested that the following information be made available to you.

Information on legislative problems in the Congress can be obtained from your county Key Man.

District	Senators (All addresses Washington, D.C.)	Telephone
	John Sherman Cooper (R)	CApitol 4-3121
	Room 125, Old Senate Office Bldg.	Extension 2542
	Thruston B. Morton (R)	CApitol 4-3121
	Room 437, Old Senate Office Bldg.	Extension 4343
	Congressmen (All addresses Washington, D.C.)	
1	Frank A. Stubblefield (D)	CApitol 4-3121
	Room 1228, New House Office Bldg.	Extension 3115
2	William H. Natcher (D)	CApitol 4-3121
	Room 117, Old House Office Bldg.	Extension 3501
3	M. G. (Gene) Snyder (R)	CApitol 4-3121
	Room 1323, New House Office Bldg.	Extension 2561
4	Frank L. Chelf (D)	CApitol 4-3121
	Room 449, Old House Office Bldg.	Extension 3465
5	Eugene E. Siler (R)	CApitol 4-3121
	Room 209, Old House Office Bldg.	Extension 4601
6	John C. Watts (D)	CApitol 4-3121
	Room 1534, New House Office Bldg.	Extension 4706
7	Carl D. Perkins (D)	CApitol 4-3121
	Room 1424, New House Office Bldg.	Extension 4935

Senior Day Programs Planned At U.K. and U. of L.

For the first time since its inception, two KSMA Senior Day Programs will be held during one year in 1964, according to Donald Chatham, M.D., Shelbyville, Chairman of the KSMA Senior Day Committee.

The first such session for the year, the Tenth Annual Senior Day Program for the University of Louisville senior medical students, will be held in Louisville on March 16 with the cooperation of the University of Louisville School of Medicine and the Jefferson County Medical Society.

The second program of the year, the first Senior Day Program for the University of Kentucky seniors, will be presented by KSMA in Lexington during May with the cooperation of the Fayette County Medical Society and the University of Kentucky Medical Center.

Harlan English, M.D., Danville, Illinois, president of the Illinois State Medical Society, will be the featured speaker at the evening session of the University of Louisville program. Doctor English's address, "The Practice as I See It," will follow a social and dinner hour at which the individual members of the Jefferson County Medical Society are host to the individual members of the senior medical class.

Sessions will get under way for the March 16 program at noon in the Rankin Amphitheater at General Hospital. The afternoon and evening sessions will be held at the Medical Arts Building where the students will be exposed to such subjects as "Legislation and Politics," "The Mechanics of Setting Up a Practice," and "Economics of Medicine."

Ky. College of Surgeons To Meet

The Kentucky Chapter, American College of Surgeons, will hold its annual meeting on Friday and Saturday April 24 and 25 at the Stouffer Inn in Louisville, according to William T. Rumage, M.D., Louisville, president. The Journal expects to carry the program of the meeting in a later issue.



"Upon arising, nose was open" . . . or how another happy patient describes the nasal decongestant action of Dimetapp Extentabs*—how would *your* patients describe it?/In Sinusitis, Colds, U.R.I., up to 10-12 hours' clear breathing on one tablet/Also available: Dimetapp Elixir, for t.i.d. or q.i.d. dosage..

Dimetapp® Extentabs®

[Dimetane® (brompheniramine maleate), 12.0 mg.; phenylpropanolamine hydrochloride, 15 mg.; phenylephrine hydrochloride, 15 mg.]

A. H. ROBINS CO., INC., RICHMOND 20, VA.

*CLINICAL REPORT ON FILE, MEDICAL DEPT., A.H. ROBINS CO., INC.

BRIEF SUMMARY: *Indications:* Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. *Side Effects:* In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. *Precautions:* Administer with caution in cardiac or peripheral vascular diseases and hypertension. *Contraindications:* Antihistamine sensitivity. Not recommended for use during pregnancy.

American College of Physicians Honors Eight Kentuckians

Eight Kentucky internists were among those recently designated as Fellows and Associates of the American College of Physicians, according to information released by Wesley W. Spink, M.D., A.C.P. president.

Elected as Fellows were: Don H. Frickman, M.D., Newport; W. Reeve Hansen, M.D., Louisville; John B. Selby, Sr., M.D., Lexington; and Raymond J. Timmerman, M.D., Fort Thomas.

Ferrell C. Lowrey, M.D, Burrell F. Radmacher, Jr., M.D., and Thomas G. Stigall, M.D., all of Louisville, and Oscar W. Thompson, Jr., M.D., Pikeville, were named Associates.

MEDICAL SCHOOL NEWS

Staff Appointments and Changes Announced by U. of L.

The trustees of the University of Louisville at their January 15 meeting approved the following School of Medicine faculty changes:

Abolrasool Ebrahimi, M.D., Nathaniel F. Pierce, M.D., and Kemal Onen, M.D., were appointed instructors in medicine. Harry Isbell, M.D., and Araham Wikler, M.D., were reappointed clinical instructors in psychosomatic research.

Promoted were: F. Norman Vickers to assistant professor of medicine, Ronald R. Kaplan, M.D., to assistant professor of community health; Nina Katerynuik, M.D., to assistant professor of psychiatry; and Lester W. Sontag, M.D., to clinical instructor of psychophysiology.

Head Librarian Named at U.K.

Omer Hamlin, Jr., has been appointed Head Medical Librarian of the Medical Center Library at the University of Kentucky College of Medicine. He replaces Alfred N. Brandon, who left to become Director and Librarian of the Welch Medical Library at Johns Hopkins University.

Prior to coming to Lexington, Mr. Hamlin was Head Librarian of the P. H. Welshimer Memorial Library at Milligan College, Milligan, Tenn. Since the summer of 1963 he has served as acting Medical Librarian at the University of Kentucky, having previously held a number of other positions within the U.K. library.

Dr. Carter Seeks Nomination

T. L. Carter, M.D., Tompkinsville, announced January 19 that he would be a candidate for the Republican nomination for Fifth District Congressman, replacing Representative Eugene Siler of Williamsburg, who will not seek reelection. Doctor Carter is currently Monroe County G.O.P. chairman.

KSMA Announces New Members Enrolled by January 20

The Kentucky State Medical Association has announced the addition of several new members and associate members who were added to the enrollment list prior to January 20, 1964.

The following are new members: B. E. Mutchler, M.D., and Claire B. Sledge, M.D., both of Paducah; and Temple Stites, M.D., and G. R. Schrodt, M.D., both of Louisville.

New associate members are: Clarence M. Ashburn, M.D., Morton Kasdan, M.D., Richard Salsitz, M.D., Nat Sandler, M.D., Mark Sexter, M.D., Donn L. Smith, M.D., and Harry Voyles, M.D., all of Louisville. Others are Herbert Hargett, M.D., Jeffersonville, Ind., and Paul E. Youngs, M.D., Georgetown, Ind.

Dr. Denham Named to Board

Mitchel B. Denham, M.D., Maysville general practitioner and a member of the Kentucky House of Representatives, has been named by Governor Edward T. Breathitt to a four-year term on the Southern Regional Education Board.

Doctor Denham, who served during his two previous terms in the House as a member of the education committee, is a 1940 graduate of the University of Louisville School of Medicine. He is a trustee of the Kentucky State Medical Association and a member of the Executive Committee.

Vaccination Program Endorsed

Representatives from KSMA, the Kentucky Chapter of the American College of Surgeons, the KAGP, and the State Health Department voted at a December 19 meeting in Frankfort to support the proposed Kentucky vaccination assistance project. The program is aimed at raising the level of public protection against four common and serious diseases—diphtheria, tetanus, whooping cough and polio.

Money for the program will come in part from a federal grant of $173,099, given to assist in the project this year. It is anticipated that additional grants will be given for two more years of intensive work.

Dr. Theiss Installed Jan. 19

Chester B. Theiss, M.D., Louisville, was installed as president of the Kentucky Society of Anesthesiologists for 1964 at the January 19 meeting of the Society held at the Holiday Inn NE, in Louisville.

Charles Moller, M.D., Lexington, was named president-elect, and will take office in 1965. Other officers elected to serve in the coming year were: Guy Morford, M.D., Owensboro, vice-president; Orville Clark, M.D., Louisville, secretary-treasurer. Lolita Weakley, M.D., Louisville, will serve as a delegate to the American Society of Anesthesiologists.

PLAN TO ATTEND
March 25 & 26, 1964

The Brown Hotel—Louisville, Kentucky

10th Annual Symposium On Cardiovascular Diseases

WEDNESDAY, March 25, 1964

Morning Session: Presiding—JACK CHUMLEY, M.D., President, Heart Association of Louisville and Jefferson County; Associate in Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

"The Relationship of Nutrition to Coronary Artery Disease": SEYMOUR H. RINZLER, M.D., Head of the Cardiac Clinic, Beth Israel Hospital; Physician in Charge—Anti-coronary Club of the New York City Department of Health, Nutrition Division, New York, New York.

"Clinical Problems in Coronary Angiography": WILLIAM L. PROUDFIT, M.D., Staff Physician, Department of Cardiology, Cleveland Clinic, Cleveland, Ohio.

"Basis for and Approach to the Primary Prevention of Premature Clinical Coronary Heart Disease": JEREMIAH STAMLER, M.D., Director, Division of Adult Health and Aging, Director, Heart Disease Control Program, Chicago Board of Health; Executive Director, Chicago Health Research Foundation; Assistant Professor, Department of Medicine, Northwestern University Medical School, Chicago, Illinois.

Panel on *"Coronary Heart Disease":* Moderator —JACK CHUMLEY, M.D., President, Heart Association of Louisville and Jefferson County; Associate in Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

Luncheon Session—*"Scenes of Cardiovascular Progress & You Are There":* J. WILLIS HURST, M.D., Professor and Chairman, Department of Medicine, Emory University School of Medicine, Atlanta, Georgia.

Afternoon Session: Presiding — GROVER B. SANDERS, M.D., Assistant Clinical Professor of Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

"External Electric Countershock in the Treatment of Refractory Tachycardia": PAUL M. ZOLL, M.D., Associate Clinical Professor of Medicine, Harvard Medical School; Visiting Physician and Associate in Medical Research, Beth Israel Hospital; and Associate Editor, Circulation, Boston, Massachusetts.

"The Clinical Application of Myocardial Histochemistry": NELSON R. NILES, M.D., Associate Professor of Pathology, University of Oregon Medical School, Portland, Oregon.

"The Trend in the Management of Cardiac Arrhythmias": J. WILLIS HURST, M.D., Professor and Chairman, Department of Medicine, Emory University School of Medicine, Atlanta, Georgia.

Panel Discussion — Moderator — WALTER S. COE, M.D., Associate Clinical Professor of Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

THURSDAY, MARCH 26, 1964

8:00 - 9:00 A.M.—Grand Rounds, Louisville General Hospital—BEVERLY T. TOWERY, M.D., Visitors Welcome

10:00 A.M.

Presiding—ROBERT L. MCCLENDON, M.D., Assistant Clinical Professor of Medicine, University of Louisville School of Medicine, Louisville Kentucky.

"Treatment of Intracranial Aneurysms": E. S. GURDJIAN, M.D., Professor of Neurosurgery and Head of the Department of Neurosurgery at Wayne State University College of Medicine, Detroit, Michigan.

"Neurovascular Compression Syndromes of the Upper Extremities": JERE W. LORD, JR., M.D., Professor of Clinical Surgery, New York University Post-Graduate Medical School, New York, New York.

"Role of Lumbar Sympathectomy in Peripheral Arteriosclerosis": EDWARD A. EDWARDS, M.D., Associate Clinical Professor of Anatomy, Harvard Medical School, Boston, Massachusetts.

Panel Discussion—Moderator, J. HERMAN MAHAFFEY, M.D., Chairman, Symposium Committee, Heart Association of Louisville and Jefferson County, Louisville, Kentucky.

Afternoon Session: Presiding — F. ALBERT OLASH, M.D., Clinical Instructor in Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

"Management of Congestive Heart Failure": JOHN H. MOYER, M.D., Professor of Medicine and Chairman of the Department of Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.

"Obesity and the Heart": JAMES K. ALEXANDER, M.D., Associate Professor of Medicine, Baylor University College of Medicine, Houston, Texas.

"Coronary Angiography, Surgery and Pathology —Post Mortem Studies": NELSON R. NILES, M.D., Associate Professor of Pathology, University of Oregon Medical School, Portland, Oregon.

What's Your Question?—Panel Discussion—Moderator, BEVERLY T. TOWERY, M.D., Chairman, Department of Medicine, University of Louisville School of Medicine, Louisville, Kentucky.

Registration Free

Sponsored by THE HEART ASSOCIATION OF LOUISVILLE AND JEFFERSON COUNTY, INC., and THE UNIVERSITY OF LOUISILLE SCHOOL OF MEDICINE.



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®
meprobamate 200 mg.+
pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

News Items

William P. VonderHaar, M.D., was named a 'Louisvillian of the Year' for 1963 by WHAS News. Doctor VonderHaar was cited for his participation in the Sabin Oral polio-immunization project. As medical chairman of the project, he was recognized by the Kentucky Public Health Association as contributing the most to Kentucky public health in 1962.

Theodore N. Guiglia, M.D., Madisonville, has become associated with the Trover Clinic in that city for the practice of internal medicine. A 1956 graduate of the University of Louisville School of Medicine, Doctor Guiglia was both an intern and resident at Letterman Army Hospital.
Organization

Plutarco A. Santana, M.D., has joined the Daniel Boone Clinic in Harlan, where he will limit his practice to pathology. Doctor Santana, a 1955 graduate of the Medical College of Santo Domingo University, interned at White Plains Hospital in White Plains, N.Y. He was a resident at hospitals in Paterson, N.J., Salem, Mass., Danville, Va., and Brooklyn, N.Y.

John D. Winebrenner, M.D., is the new Area Administrator of the UMWA Welfare and Retirement Fund in Louisville. A 1938 graduate of Indiana University Medical School, he is a Fellow of the American College of Physicians and of the College of Preventive Medicine. Doctor Winebrenner held the same position in Knoxville, Tenn. for 15 years. Prior to that time he was Public Health Advisor for the Department of the Army in Germany.

Giovanni Raccuglia, M.D., is now associated with the University of Louisville School of Medicine, where he is chief of the section of Hematology. Doctor Raccuglia, a native of Rome, Italy, received his M.D. in 1950 from the University of Rome, and interned in his native city. His residency was served partly in Rome, and in this country in both Maryland and Ohio. He was previously on the staff of the University of Michigan.

WANTED

Full-time industrial physician for large plant of the Du Pont Company in Parkersburg, West Virginia—a growing industial area on the Ohio River. Salary Open. Permanent employment. Excellent opportunity. Please contact H. F. Gilbert, M. D., E. L. DuPont de Nemours & Company, P. O. Box 1217, Parkersburg, West Virginia.

cut Rx writing by 2/3 in colds, flu or grippe

NAME _____

ADDRESS _____

℞

No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct... economically sound... to specify

ANTITUSSIVE/DECONGESTANT/ANALGESIC
'EMPRAZIL-C'® TABLETS

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. **Caution:** While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. **Supplied:** Bottles of 100 tablets.

Also available without codeine as 'EMPRAZIL'® TABLETS

Complete literature available on request from Professional Services Dept. PML.



BURROUGHS WELLCOME & CO (U.S.A.) INC.

Tuckahoe, N. Y.



County Society Reports

Breckinridge

The Breckinridge County Medical Society has been incorporated as a non-profit corporation to be known as The Breckinridge County Medical Society, Inc., according to William Cates, M.D., Cloverport.

Officers elected at a recent meeting to serve during 1964 were: William Hatfield, M.D., Irvington, president; James G. Sills, M.D., Hardinsburg, vice-president; and Doctor Cates, secretary-treasurer.

Floyd

New officers for 1964 were elected by the Floyd County Medical Society at the January 3 meeting held at the Health Department Building in Prestonsburg. Those named were: J. Douglas Adams, M.D., Prestonsburg, re-elected president; Lowell Martin, M.D., Garrett, vice-president; and R. L. Hall, M.D., Prestonsburg, secretary-treasurer. Doctor Hall was also named as delegate to the KSMA.

The Society voted unanimously to accept James A. Holbrook, M.D., Prestonsburg, as a member.

Committee chairmen for the coming year were also named at the meeting. Following is a list of the committees and their respective chairmen: Diabetes—C. L. Allen, M.D., Martin; Public Relations—Francis Sherman, M.D., Martin; Rural Health—Doctor Hall; Aged—Doctor Adams; School Health—Doctor Holbrook; Emergency Medical Care—Doctor Martin. Doctor Adams was selected to act as Legislative Man.

McCracken

"Hypercholesterolemia" was the subject of the scientific program presented by Fred Goldner, Jr., M.D., chief of medical services at St. Thomas Hospital in Nashville, at the November 20 meeting of the McCracken County Medical Society held at Boswell's Restaurant in Paducah.

At the business meeting following the scientific session, the Society approved and agreed to support the proposed Associate Degree Program to prepare students for registration as registered nurses at Paducah Junior College.

An encouraging progress report from the Emergency Medical Services Committee was presented by W. Burton Haley, M.D., Paducah, chairman.

Muhlenberg

James Brashear, M.D., Central City, was elected 1964 president of the Muhlenberg County Medical Society at the December 2 meeting of the Society, taking over the office from 1963 president Charles Shipp, M.D., Greenville.

Other officers named were: Mark Judge, M.D., Central City, vice-president, and Hylan H. Woodson, M.D., Greenville, delegate to the KSMA. George F. Brockman, M.D., Greenville, was re-elected secretary.

In reviewing the past year's activities, Doctor Shipp, the retiring president, expressed appreciation for the cooperation received from various groups and individuals in carrying out the Society's broad programs of health protection within the county.

In Memoriam

WALKER OWENS, M.D.
Mt. Vernon, Ky.
1878-1963

Walker Owens, M.D., 85, retired Rockcastle County public health physician, died December 5 at Mount Vernon after a long illness. Doctor Owens, who graduated in 1904 from the Hospital College of Medicine in Louisville, began his practice in Rockcastle County shortly afterward. In 1931 he organized the county Health Department and served as its head until his retirement in 1961. His widow, Mrs. Loda Owens, served as president of the Woman's Auxiliary to KSMA in 1947.

NEWTON G. ZINN, M.D.
Alexandria, Ky.
1869-1963

Newton G. Zinn, M.D., who at the age of 95 still maintained his general practice at Alexandria, died Sunday, December 8, after a brief illness. An 1894 graduate of the Kentucky School of Medicine in Louisville, Doctor Zinn opened his office in Alexandria in 1903. He was one of the founders of both the Bank of Alexandria and the Farmers State Bank of Alexandria, and had served as president of both.

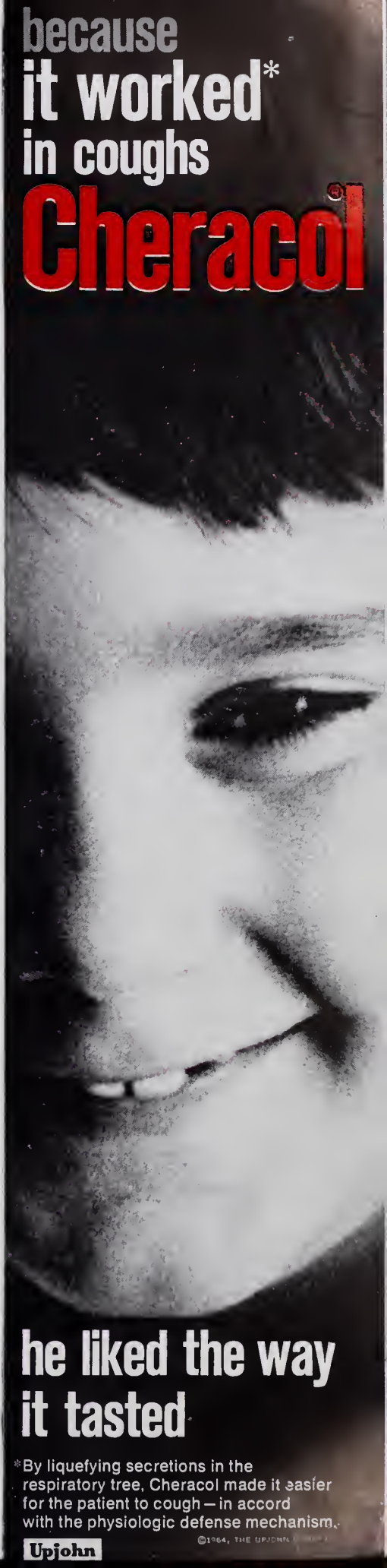
ALBERT B. HOSKINS, SR., M.D.
Beattyville, Ky.
1873-1963

Albert B. Hoskins, Sr., M.D., 90, Beattyville general practitioner for 52 years, died December 9 after a long illness. Doctor Hoskins, who was retired, graduated in 1905 from the Hospital College of Medicine in Louisville. An emeritus member of KSMA, he was a former mayor of Beattyville and active in church affairs.

GLENN BREWSTER, M.D.
(formerly) Hustonville, Ky.
1880-1963

Glenn Brewster, M.D., 83, general practitioner at Hustonville for ten years, died December 5 in Cincinnati, where he had lived since his retirement in 1960. He had previously practiced for 48 years in McDowell County, West Virginia. Doctor Brewster was a 1903 graduate of the Louisville College of Medicine.

"Progress in Pediatrics" will be the topic of the Cleveland Clinic Foundation's postgraduate education course to be presented February 26 and 27 in Cleveland, Ohio. A registration fee of $30 will be charged. Registration is limited. For information write to the Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, Ohio, 44106.

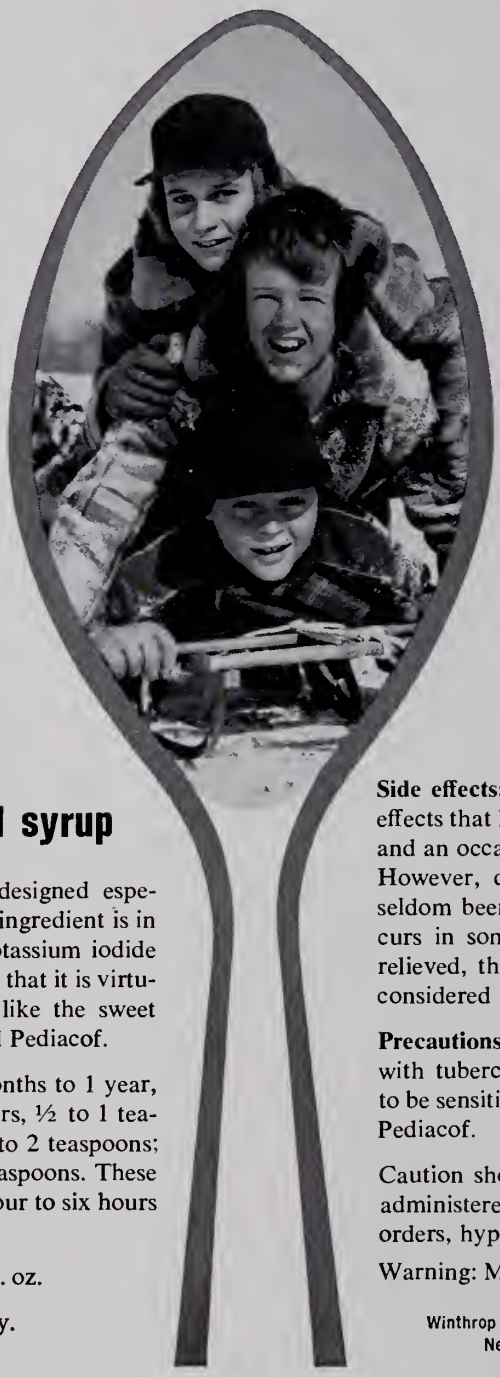


Special cough formula for children

Pediacof®

Each teaspoon (5 ml.) contains codeine phosphate 5 mg., Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride) 2.5 mg., chlorpheniramine maleate 0.75 mg. and potassium iodide 75 mg.

soothing decongestant and expectorant



bright red, pleasant-tasting, raspberry-flavored syrup

Pediacof is different. It is designed especially for children, and each ingredient is in the right proportion. The potassium iodide in Pediacof is so well masked that it is virtually unnoticeable. Children like the sweet raspberry flavor of bright red Pediacof.

Dosage: Children from 6 months to 1 year, ¼ teaspoon; from 1 to 3 years, ½ to 1 teaspoon; from 3 to 6 years, 1 to 2 teaspoons; and from 6 to 12 years, 2 teaspoons. These doses are to be given every four to six hours as needed.

How supplied: Bottles of 16 fl. oz.

Available on prescription only.
Exempt Narcotic.

Side effects: The only significant untoward effects that have occurred are mild anorexia and an occasional tendency to constipation. However, discontinuance of Pediacof has seldom been required. Mild drowsiness occurs in some patients but, when cough is relieved, the quieting effect of Pediacof is considered beneficial in many instances.

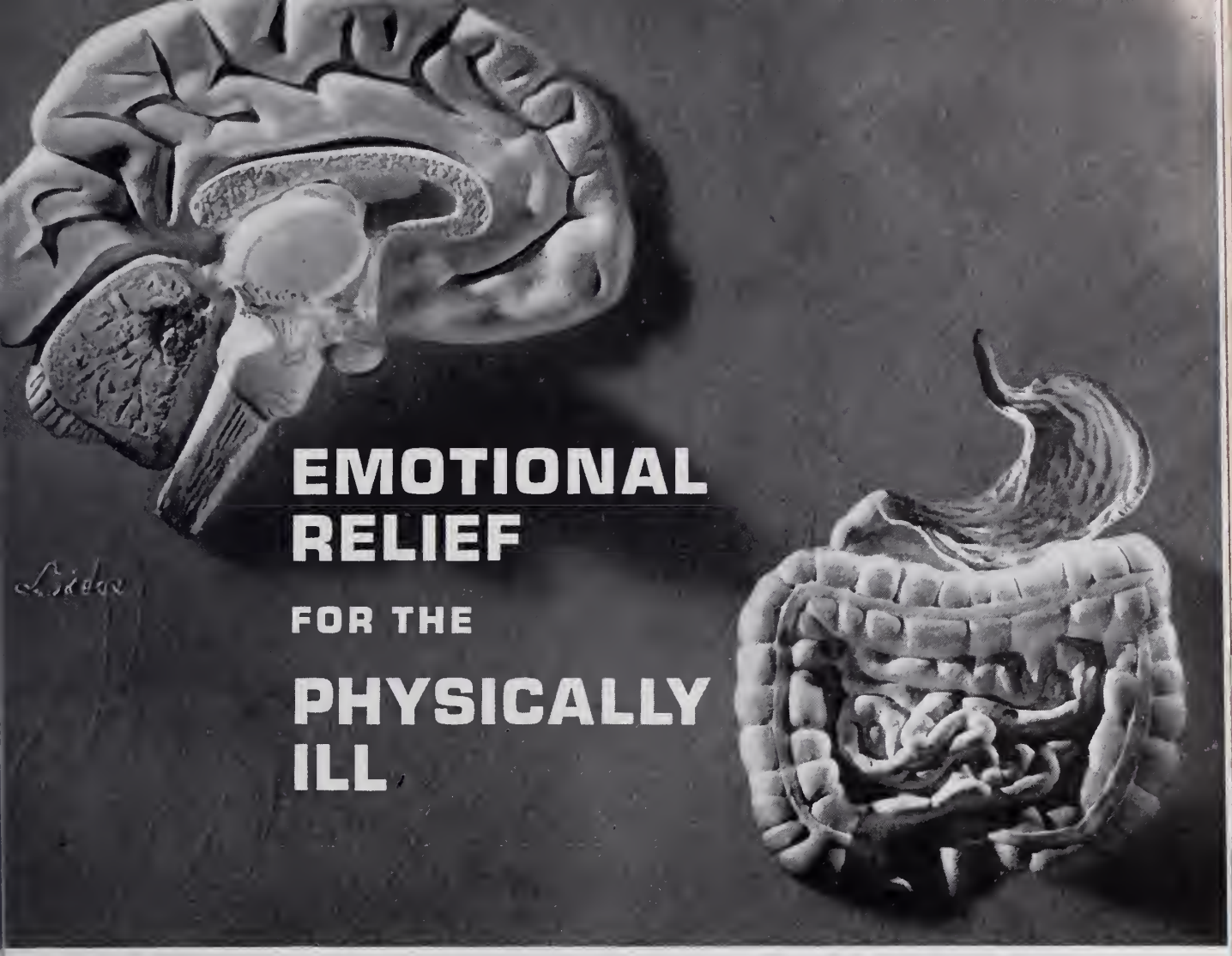
Precautions and contraindications: Patients with tuberculosis or those who are known to be sensitive to iodides should not be given Pediacof.

Caution should be exercised if Pediacof is administered to patients with cardiac disorders, hypertension or hyperthyroidism.

Warning: May be habit forming.

Winthrop Laboratories
New York, N.Y.

Winthrop



RELIEVES ANXIETY, APPREHENSION AND TENSION...



All day long

. . . keeps the patient calm, and the mind clear.



All night too

. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400

(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CME-805

WALLACE LABORATORIES *Cranbury, N. J.*

Council on Medical Education and Hospitals

Walter S. Coe, M.D., Louisville, Chairman

Louisville **November 14, 1963**

The Council on Medical Education and Hospitals at its first meeting of the Associational year discussed the duties of the committees serving under the Council and submitted a proposal of these duties to the Board of Trustees as an addition to the KSMA Bylaws. The Council also recommended to the Board that the Faculty Scientific Achievement Awards be presented at the President's Luncheon during the Annual Meeting.

With the discontinuance of the Committee on Continuing Education, the KSMA Executive Committee named the Council on Medical Education and Hospitals as being responsible for the operation of the Postgraduate Medical Education Fund.

A questionnaire on "town and gown" relationships was reviewed. The questionnaire will be distributed to KSMA members when it has been put into final form.

Mental Health Committee

Frank M. Gaines, M.D., Louisville, Chairman

Louisville **October 24, 1963**

A Kentucky Congress on Mental Health was the main item considered by the Mental Health Committee at its meeting when it was determined that the day-long congress would be held at the Kentucky Hotel in Louisville, Thursday, May 14, 1964. The committee requested the county medical societies to appoint a Mental Health Committee and submit the chairman's name to the KSMA Headquarters Office.

The chairman announced that a new Sub-Committee on Alcoholism had been appointed to serve under the Mental Health Committee. He also announced that a series of AMA records on mental illness and health would be presented as a public service over some fifteen hundred (1500) radio stations.

Senior Day Committee

Donald Chatham, M.D., Shelbyville, Chairman

Louisville **November 13, 1963**

The KSMA Senior Day Committee decided to hold the Tenth Annual Senior Day for the University of Louisville on Monday, March 16, 1964 at the Medical Arts Building, Louisville, and the First Senior Day for the University of Kentucky sometime during May. Harlan English, M.D., president of the Illinois State Medical Society, will be the principle speaker for the University of Louisville Senior Day program.



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

(Research and Teaching Exhibits)

1964 Annual Meeting — Kentucky State Medical Association

Convention Center — **Louisville, Kentucky** — **Sept. 29, 30; Oct. 1**

Fill Out and Mail to:

BENJAMIN B. JACKSON, M.D., Chairman

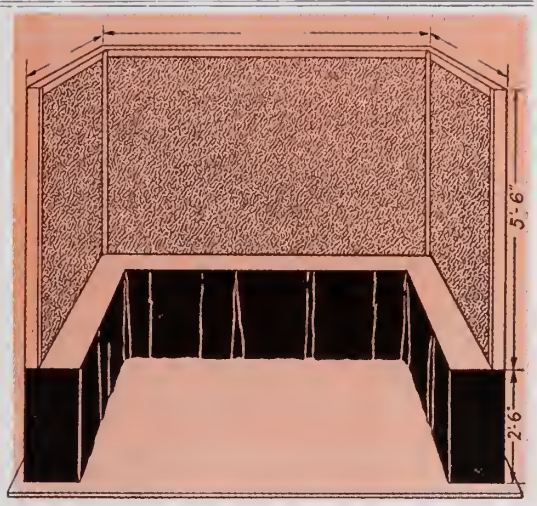
Committee on Scientific Exhibits

Kentucky State Medical Association

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1964

Dimensions and structure of KSMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....

   .....

   Institution (if desired): .....

   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

   Charts and Posters.... Photographs.... Drawings.... X-rays....

   Specimens.... Moulages.... Other Material ..... (Describe)
6. Booth Requirements:

   Amount of wall space needed? .....

   Back wall .....Side walls (All side walls are 4') .....

   Square feet needed? .....Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

Signature of Applicant

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KSMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator — MARGARET KELLY, R. N., Director of Nurses

NEW MEN'S SHOP



. . . in our **NEW SOUTHERN OPTICAL BUILDING**, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

GUILD OPTICIANS

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th



WHY DOES ONE ANTIBIOTIC GIVE UP TO 2 EXTRA DAYS' ACTIVITY?

Because it is more resistant to disintegration, has a lower renal clearance rate than earlier tetracyclines[1]...a favorable depot effect resulting from protein binding and greater mg. potency...all giving higher, sustained *in vivo* activity which continues long after the last dose.

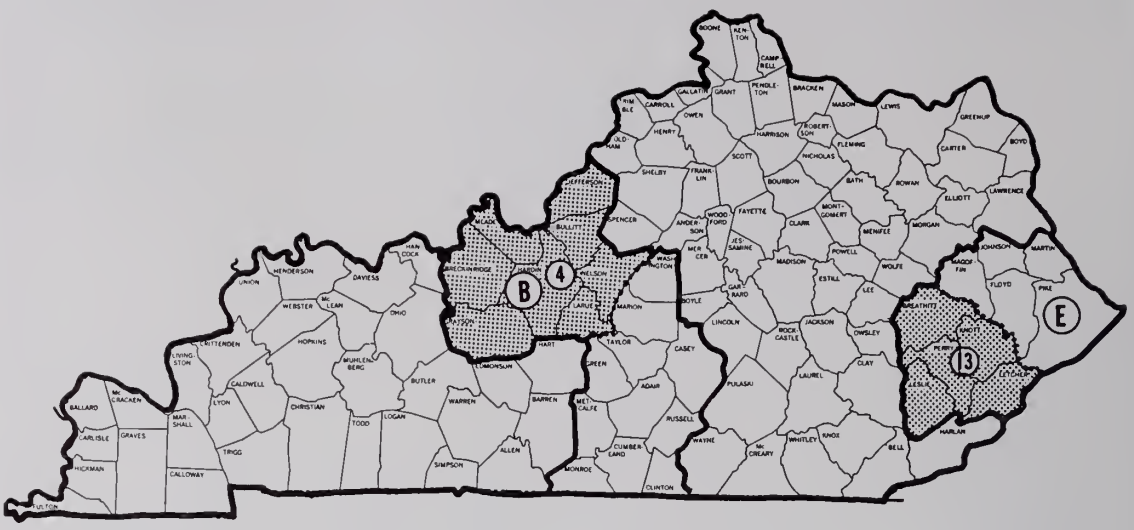
DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections — respiratory, urinary tract and others — in the young and aged — the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.
Side Effects typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules*, 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Kunin, C. M.; Dornbush, A. C., and Finland, M.: Distribution and Excretion of Four Tetracycline Analogues in Normal Young Men. *J. Clin. Invest.* 38:1950 (Nov.) 1959.

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
7517-3

Lederle



Area subject to ACIR study of injury producing passenger car accidents. Jefferson County, however, will be included for the first four months only.

February 1, 1964 marked the beginning of the Fourth Sampling Period for the Kentucky-Cornell Automotive Crash Injury research program, a continuing project being carried on in cooperation with the Kentucky State Medical Association, the State Department of Health, and the State Police. The dark areas on the map are those from which automobile injury samples will be taken during the six-month sampling period.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
203 Parkside Building, 4140 Shelbyville Road, Louisville 7
Mailing Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884

Digest of the Minutes of the KSMA Board of Trustees Meeting December 12, 1963

The second meeting of the Board for the 1963-64 associational year was held at the headquarters office. KSMA Delegates to the AMA reported on the two resolutions that were introduced by our delegation at the Portland Interim Meeting of the AMA in December. It was explained that while the AMA agreed in principle with both resolutions, that various agencies of the AMA were working on the suggestions covered by the two resolutions.

The Board considered reports from its members relating to internal matters and acted on them.

The report of the Council on Legislative Activities was heard and its recommendation that the Association support the legislative proposal to strengthen the Medical Examiners System was approved.

The Board agreed unanimously to support the request of the University of Louisville for increased appropriation by the 1964 Kentucky Legislature.

The Board voted to resist any legislation designed to change Tuberculosis Hospitals into Chronic Diseases Hospitals.

It was agreed by members of the Board to go along with the State Board of Health in drafting regulations providing for limited licensure for interns and residents on an annual basis. The Board voted to resist the passage of proposed legislation by the Kentucky State Association of Registered Nurses in the form available at that time. The Board after further consideration decided not to seek to introduce a Good Samaritan Bill to be introduced into the 1964 session of the Legislature.

It decided to support the legislation to be introduced by the Pharmacy Association as revised.

The Board agreed to make an appropriation in the amount of $7,500 for the coming year to the Kentucky Educational Medical Political Action Committee's Board of Directors for educational purposes, and the Board also appointed directors for KEMPAC for the 1964 calendar year.

Under the recommendations of the Council on Medical Education and Hospitals, the Board voted to have the faculty achievement awards presented each year during the President's Luncheon at the Annual Meeting.

Also, the Board voted on a recommendation of the Council on Medical Education to continue the present appropriation for postgraduate medical education and finally, approval was given for the paying of honoraria to the Senior Day speakers.

The procedures to be followed by the KSMA Placement Service were reviewed in connection with an Eastern Kentucky situation and policy reaffirmed. The Board nominated three physicians in accordance with the Kentucky Revised Statutes from which the Governor will name one to fill the position on the State Board of Health held by Carl Fortune, M.D., Lexington.

Appreciation was officially expressed to Eugene Conner, M.D., the editor of the special Sixtieth Anniversary Issue of The Journal. It was indicated that twenty-three of the twenty-eight Board Room Chairs have been contributed by members. In other actions, the Board voted not to purchase liability insurance for The Journal; to support the request of the Green County Historical Society for funds to create a park for Jane Todd Crawford and to publicize among county societies the fact that the members of the Kentucky Junior Chamber of Commerce were collecting drugs for Project Concern to be sent to a missionary physician in Hong Kong.

The Board agreed to hold its next meeting beginning at 9:00 a.m., Wednesday April 22 at Jenny Wiley State Park, which is the day prior to the Fourteenth Annual Interim Meeting.

Dr. Neustadt Heads Foundation

David H. Neustadt, M.D., clinical instructor in Medicine at the University of Louisville, was elected president of the Kentucky chapter of the Arthritis and Rheumatism Foundation at the January 6 meeting at the Pendennis Club in Louisville. Harvey R. St. Clair, M.D., Louisville, was named honorary board chairman, and Robert McClendon, M.D., Louisville, was elected a director.

Dr. Witten Named Consultant

Carroll L. Witten, M.D., Louisville, has been named a consultant to the Pennsylvania State University in the establishment and operation of the planned Milton S. Hershey Medical Center. He will serve as a consultant to the Advisory Committee and to the University in both the establishment and operation of the medical center.

WANTED

GENERAL PRACTITIONER

AS FAMILY PHYSICIAN—To serve with quality Medical Group with Board Specialists, West Virginia College City of 30,000 near University Medical Center.

Starting salary $15,000-16,000; annual increments, excellent fringe benefits and opportunity

For information, call collect
Administrator, Area Code 304-366-0700

Case Discussion

Continued from Page 137

wall. The ability of these patients to live a productive and comfortable life following operation must be witnessed to be appreciated.

The problem of evaluating the worth of this admittedly mutilating procedure must be considered in light of the inevitable death of the patient if it is not undertaken. The cure rate is sufficiently good to warrant its use in selected patients with advanced cervical cancer.

Summary

1. The indications for surgery in the treatment of carcinoma of the cervix have been reviewed. Although radiation therapy is of primary benefit in most instances of cervical carcinoma, surgical excision has a definite role in both very early and advanced cervical cancer.
2. Carcinoma in situ discovered by cytological examination according to the Papanicolaou technique can be cured in over 90% of the cases by total hysterectomy. Proper timing of this operation is discussed.
3. Advanced cervical carcinoma, or its post-irradiation recurrency, may in selected patients be cured by pelvic evisceration consisting of removal of the involved blatter, rectum. uterus and vagina. Cure rates approximating 30% after 5 years can be anticipated from patients with such advanced lesions.
4. Both the benefits and the clinical implications of this procedure are discussed in an effort to delineate the indications for this type of surgery.

Bibliography

1. Liu, Winifred: An Introduction to Exfoliative Cystology, Charles C. Thomas, Springfield, Illinois, 1959.
2. Friedell, G. H., Hertig, A. T., Younge, P. A.: Carcinoma in Situ of the Uterine Cervix, Charles C. Thomas, Springfield, Illinois, 1960.
3. Carscaden, James A.: Gynecologic Cancer 3rd Edition, Williams and Wilkins, 166-67, 1962.
4. Twombly, G. H.: The Technique of Radical Hysterectomy for Carcinoma of the Cervix, Cancer 3:975, 1950.
5. Brunschwig, A.: The surgical Therapy of Stage I Carcinoma of the Cervix, Cancer 13:34, 1960.
6. Allen, W. M., Sherman, A. I., Camel, H. M.: Radiogold in the Treatment of Cancer of the Cervix, Radiology 70:523-27, 1958.
7. Bricker, E. M., Modlin, J. L.: The Role of Pelvic Evisceration in Surgery, Surgery 30:76, 1951.
8. Bricker, E. M.: Substitution for the Urinary Bladder by the Use of Isolated Ileal Segments, Surgery Clinics of North America, :36, 1956.
9. Bricker, E. M., Butcher, H. R., Jr., Lawler, W., Jr., McAfee, C. A.: Surgical Treatment of Advanced and Recurrent Cancer of the Pelvic Viscera: An Evaluation of Ten Years Experience, Annals of Surgery, 152:388, 1960.
10. Brunschwig, A., Pierce, V. K.: Partial and Complete Pelvic Exenteration: Progress Report Based Upon the First 100 Operations, Cancer 3:972, 1950.
11. Brunschwig, A., Daniel, W.: Total and Anterior Pelvic Exenteration, Surg., Gynec. and Obstet., 99:324, 1954.
12. Brunschwig, A., Daniel, W.: The Surgical Treatment of Cancer and the Cervix, American Journal Obstet. and Gynec., 82:60, 1961.
13. Perez-Messa, C., Spjut, H. J.: Persistant Post-Irradiation Carcinoma of Cervix Uteri: A Pathologic Study of 83 Pelvic Exenteration Specimens, A.M.A Arch. Pathology, Chicago, 75:462, 1963.

CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of mental and nervous disorders, and addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director



Side Effects: No serious toxic reactions are to be expected. Dryness of the mouth, blurred vision, difficult urination, and flushing and dryness of the skin may occur with excessive and prolonged dosage. Precautions: Use with care in incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced hepatic or renal disease, or idiosyncrasy to any component.

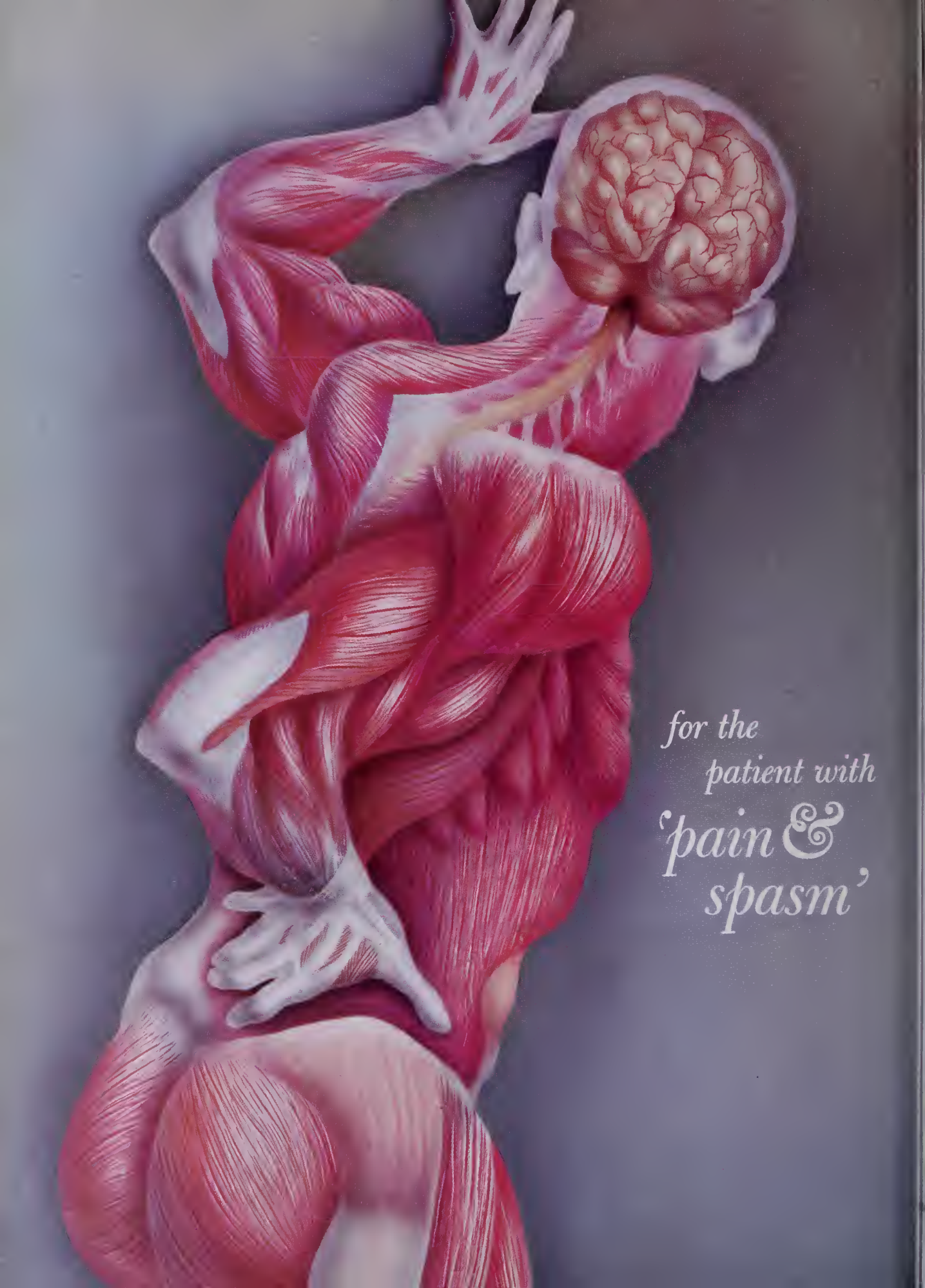
In each Tablet, Capsule or 5 cc. Elixir		In each Extentab
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital	(¾ gr.) 48.6 mg.

(Warning: May be habit forming)

Prescribed by more physicians than any other antispasmodic —well over 5 billion doses!

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

*This one at Big Basin, California


for the
patient with
'pain &
spasm'

pain is almost invariably a presenting symptom in cases of skeletal muscle *spasm*

In some instances, the pain subsides on relaxation of the muscles in spasm. In others, relaxant therapy alone fails to give adequate relief, and supplementary analgesia (and possibly sedation) are indispensable, as in cases of:

provocative pain, when muscle spasm is triggered by some painful underlying musculoskeletal defect.

residual pain, when relaxation of severe spasticity leaves a degree of myalgia that tends to reinvoke spasm.

severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

emotionally aggravated pain, when anxiety or agitation creates tension that thwarts the efficacy of both relaxant and analgesic medication.

In such cases, ROBAXISAL and ROBAXISAL-PH have proven highly effective in assuring decisive and comprehensive relief. The ROBAXISAL formula—of ROBAXIN (methocarbamol), the potent muscle relaxant, together with aspirin, the time-tested and proved analgesic—produces higher plasma salicylate levels than equivalent doses of aspirin alone, and serves effectively to control both spasm and pain. ROBAXISAL-PH's combination of ROBAXIN (methocarbamol) with the analgesic-sedative ingredients of the PHENAPHEN formula—including phenobarbital—helps additionally to ease apprehension.

ROBAXISAL®

Robins

Each pink-and-white laminated Tablet contains:
ROBAXIN (methocarbamol, Robins) .....400 mg. Aspirin (5 gr.).....325 mg.
U.S. Pat. No. 2770649

ROBAXISAL®-PH

Each green-and-white laminated Tablet contains:
ROBAXIN .....400 mg. (methocarbamol, Robins)
Phenacetin (1½ gr.)....97 mg.
Aspirin (1¼ gr.).....81 mg.
Hyoscyamine sulfate 0.016 mg.
Phenobarbital (⅛ gr.)....8.1 mg.
(Warning: May be habit forming)



"PAIN & SPASM"
—a two-headed dragon!

ROBAXISAL and ROBAXISAL-PH are indicated in strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

Side effects such as lightheadedness, slight drowsiness, dizziness and nausea may occur rarely in patients with intolerance to drugs, but they usually disappear on reduction of dosage.

Contraindicated for patients hypersensitive to any component of the formulations. There are no specific contraindications to methocarbamol, and untoward reactions are not to be expected.

A. H. ROBINS CO., INC., Richmond 20, Virginia



GUIDE TO MEDICAL WRITING: by Henry A. Davidson, M.D.; published by the Ronald Press Company, New York, 1957; 338 pages.

This book by the editor of the Journal of the Medical Society of New Jersey is designed to provide guiding principles governing the writing of technical papers in such health fields as medicine, dentistry, nursing, and veterinary medicine. Helpful hints are provided regarding such varied topics as grammar and syntax, preparation of a bibliography, and the use and abuse of statistical data. The book is at its best when offering practical suggestions about the preparation of the final manuscript; the sections on grammar and usage are necessarily sketchy and superficial.

The author's own editorial experience is obvious, and his clear and mildly entertaining style makes the book a painless one to read. In general, his suggestions are ones which, if followed, would increase the would-be author's chance of having his article accepted.

Some editors might differ with Doctor Davidson in the matter of standard abbreviations of literature citations; and his own proofreader appears to have failed him in the last chapter, where we read such incorrect listings as "American Journal of Gynecology and Obstetrics" for "American Journal of Obstetrics and Gynecology", and "Journal of the Kentucky Medical Association" for "Journal of the Kentucky State Medical Association".

Doctor Davidson's book is a useful but expendable addition to the "how to" literature on medical writing. Experienced medical writers will not need to consult it, while only a rare occasional contributor is likely to read it with sufficient attention to profit by it.

Douglas M. Haynes, M.D.

REVIEW OF PHYSIOLOGICAL CHEMISTRY: by Harold A. Harper, M.D.; Ninth Edition; Published by Lange Medical Publications, Los Altos, Calif., 1963; 426 pages; Price, $6.00.

The author states in his Preface that "This book is intended to serve as a critical and concise summary of that which is considered essential in the expanding universe of physiological chemistry," and "It is . . . anticipated that the Review will not only meet the needs of the physician who is preparing for state and specialty boards but that it will also serve as one means of maintaining the practicing physician's perspective . . ."

There is no doubt that the volume contains an enormous amount of material in less than 450 pages and that much of the material can be truly "considered essential." Most of the important compounds are represented by structural formulae and most of the recognized metabolic pathways are shown in full. The book thus does provide a concise summary which can be extremely valuable for review purposes.

With respect to both metabolic pathways and several topics of great current interest the material is extremely up-to-date. As examples may be mentioned phenyl ketonuria, the porphyrias, the hemoglobinopathies, the synthesis of glycogen and the action of insulin. In a number of instances the material is more complete or more recent than that available in standard textbooks. The book thus does provide a means for informing the practicing physician and perhaps for maintaining his perspective.

Unfortunately, this reviewer cannot agree that the Review is a critical summary. Some topics are treated much more thoroughly than others which seem of comparable importance, and some unimportant topics are treated along with others of great importance. A number of frank errors have been noted, together with a greater number of instances where inaccurate statements can easily confuse the reader who is not in a position to judge for himself.

For such reasons, this reviewer and his colleagues cannot applaud the indiscriminate use of this book by beginning medical students in place of a textbook. It can find a use as a Review for a specific purpose, as its title suggests, whether for the physician or the student preparing for board examiantions. Even in such an emergency, it should be used like many other therapeutic agents, with discrimination, with full recognition of its limitations and its deficiencies, as well as its undoubted considerable merits for the purpose at hand.

John Fuller Taylor, Ph.D.

PHYSICAL DIAGNOSIS: by John A. Prior, M.D., and Jack S. Silberstein, M.D.; Second Edition; Published by The C. V. Mosby Co., St. Louis, Mo., 1963; 432 pages; Price, $8.50.

This book on physical diagnosis is written in the classical mold. An attempt has been made to make the book as comprehensive as possible by having nine contributors in various fields of medicine write various sections. While the book is lucid and well organized, it does not seem to offer much more than do several standard texts now available.

Books on physical diagnosis constantly run the risk of saying either too little or too much. One would prefer in this book, for example, a somewhat more detailed description of disease states and pathologic physiology in relation to physical findings. There is especially a lack in this regard in the section on physical diagnosis of the cardiovascular system where there is little discussion of the physiology and pathology which determine the physical findings.

Continued on next page

The section on gallop rhythm takes up slightly less than one page in the whole book with little review of the important and large literature on this subject. In the section on cardiac murmurs there is relatively little discussion concerning the physics of blood flow and sound production.

It may be that such topics are better discussed in a different type of book but a more comprehensive correlation between pathologic physiology and physical diagnosis is desirable.

Leonard Leight, M.D.

Writing Awards Offered by AMA

Five awards of $1,000 each will be presented for outstanding reporting on health and medicine by the newly-formed Medical Journalism Awards program of the American Medical Association. The AMA urged state medical associations to encourage local media writers to enter.

Awards will be given in five categories—newspapers, magazines, radio, television, and newspaper editorial writing—though not for work involving the relaying of medical knowledge to the medical profession and allied professions. Kentucky physicians may make recommendations. For information contact the 1964 Medical Journalism Awards Committee, AMA, 535 N. Dearborn St., Chicago.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

MURFREESBORO - VACANCIES: STAFF PHYSICIANS for 1275 bed neuropsychiatric hospital, including 350 general medical and geriatric. Modern facilities for diagnosis and treatment of mental illness. Salary $11,150 to $18,405 depending on qualifications; fringe benefits; cost of moving to Murfreesboro will be paid by Veterans Administration; visit here for evaluation can be arranged at our expense. Excellent educational opportunities for students in this area. Contact Director, Veterans Administration Hospital, Murfreesboro, Tenn.

Wholesale Drugs

and

Physicians Supplies

JOHN T. VIE CO., INC.

WH 4-7784 New Albany, Ind.

PHYSICIAN WANTED

Unlimited opportunity for General Practitioner with emphasis on Obstetrics. Lease modern air-conditioned office. Fully equipped and ready for immediate occupancy. 30-year practice waiting for the right man.

Write: Mrs. A. J. Pauli, Executrix
3023 Tremont Drive
Louisville 5, Kentucky

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem.

KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

Chatham CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey

Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

FOR SALE

Physician's waiting room furniture, consultation room equipment, and three treatment rooms fully equipped, all purchased in the last eight years.

Two-story brick veneer building, excellent physician's office on the first floor, modern attractive four-room apartment on the second floor, finished basement.

Stair glide purchased new, used only two months — bargain.

Write: J. O. Mattox, M.D.
903 Highland Avenue
Carrollton, Ky.

GET IN THE MIDDLE of THINGS . . .

Heyburn Building

The preferred professional address

A central location at the hub of public transportation; adequate nearby parking. Complete service with uniformed attendants.

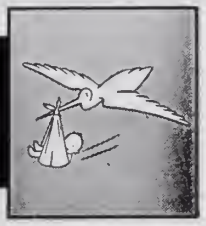
All specialties are represented in The Heyburn Building. This has proven to be most helpful where consultation is indicated.

For information, contact:

DOWNTOWN LOUISVILLE MANAGEMENT, INC.
1401-A Heyburn Building **587-6982**



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #154. A 20 year old, married, white primigravida under the care of a private physician was seen initially in the second month of pregnancy.

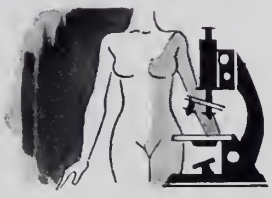
Date	4/4/61	5/16/61	6/19/61	7/19/61	8/16/61	9/6/61
BP	110/70	112/60	120/80	120/80	120/68	110/70
Weight	115	119½	126	134	137	142¾
Urine	trich	tr alb			bacteria	bacteria
RH & VDRL	- non reactive					
Date	9/29/61	10/9/61	10/24/61	11/20/61	12/2/61	12/12/61
BP	108/60	120/80	124/76	120/80	120/80	
Weight	142¼	147	152½	158	162½	
Urine		tr alb	sugar tr	bacteria	bacteria	

The patient gained weight excessively to a total of 47½ pounds. On December 13, 1961, she was four days past her expected date of delivery as calculated from the menstrual history. X-ray pelvimetry films were made and showed the fetus to be in LOA, low in the pelvis, with no over-lapping. The measurements were not recorded.

The patient was admitted for induction of labor with a Pitocin infusion. The first stage of labor lasted 16 hours. The second stage continued for four hours with the presenting part changing in delivery to a posterior position. A high forceps (sic) delivery was attempted by one physician with general anesthesia and was unsuccessful, so another physician delivered at 4:17 p.m. by high forceps (sic) a living, 9 lb. 14 oz. girl whose respiration was delayed. The placenta was expressed intact spontaneously at 4:20. Excessive bleeding from the cervix was then encountered. This was controlled with sutures, but sudden, uncontrollable hemorrhage recurred shortly. An unsuccessful attempt was made to start Dextran intravenously. At 4:25 p.m., the patient was pronounced dead after failure to respond to adrenalin and external cardiac massage. There was no autopsy. The cause of death was listed as postpartum hemorrhage.

Comments:

The Committee classified this a direct obstetric death with preventable factors on the part of the physician. From the information supplied, this seemed entirely to be a case of an attempted high forceps delivery in the face of great disproportion, resulting in delivery of a living infant at the expense of a dead mother from what was probably an unrecognized rupture of the lower uterine segment.





Baker's D

VOL. 1 NO. 1 FORECAST: HAPPY MOTHERS AND BABIES

NEW 'UNDERC SOLVES DIAPE

Trio of suspects identified...

Bacteria a Prime Culprit Organisms such as Bacillus ammoniagenes and Alcaligenes faecalis metabolize urine into chemical irritants. Proper laundering of diapers helps reduce number of organisms, but cannot completely eliminate bacterial growth.

Ammonia and Urea Implicated Ammonia produced by microorganisms is a major cause of skin irritation that leads to diaper rash.

The Moisture—Maceration—Infection Cycle Moisture from urine and feces, combined with diaper friction, results in damp, macerated skin—an ideal environment for bacterial proliferation. In the absence of energetic countermeasures, the moisture—maceration—infection cycle continues, leads to chronic diaper rash problems.



aby News



BAKER LABORATORIES, INC.

OVER' AGENT
R RASH CASE!

Diapersil successful!

Bactericidal to Ammonia-Splitting Pathogens Diapersil contains benzalkonium chloride, which is rapidly 'cidal' to organisms implicated in diaper rash. Benzalkonium chloride has a proven record of effectiveness and safety.

Continued 'Uripellent' Protection Silicones in Diapersil form a water-resistant coating which shields the skin from bacterial by-products and from maceration. Silicones have been found outstandingly effective in diaper rash, even when other types of therapy have failed.

Soothing to Inflamed Skin Panthenol, incorporated in a soothing and non-sensitizing base, relieves itching and pain, and gently promotes healing. Diapersil thus provides prompt symptomatic relief in diaper rash as well as in other pediatric skin conditions.

BAKER'S DIAPERSIL™ CREME

Formula: panthenol, dimethylpolysiloxane, benzalkonium chloride, in a watermiscible, non-sensitizing cream base

To treat and prevent diaper rash, excoriated buttocks, chafing, heat rash and similar conditions

BAKER LABORATORIES, INC. Subsidiary of U.S. Vitamin & Pharmaceutical Corp.

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS — 1963-1964

GEORGE P. ARCHER, Prestonsburg ..... President
DELMAS M. CLARDY, Hopkinsville ..... President-Elect
DAVID M. COX, Louisville ..... Immediate Past President
CARLISLE MORSE, Louisville ..... Vice President (Central)
CARL C. COOPER, Bedford ..... Vice President (Eastern)
JOHN DICKINSON, Glasgow ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, Corbin ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
DOUGLAS E. SCOTT, Lexington ..... Chairman of the Board of Trustees
GABE A. PAYNE, JR., Hopkinsville ..... Vice Chairman of the Board of Trustees

DELEGATES TO THE A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

BOARD OF TRUSTEES

First District ..... O. LEON HIGDON, Katterjohn Building, Paducah 1965
Second District ..... HOWELL J. DAVIS, 330½ Allen Street, Owensboro 1964
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville (serving interim term) 1964
Eighth District ..... DON JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1964
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1964
Eleventh District ..... HUBERT JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... CLYDE C. SPARKS, Mayo Arcade, Ashland 1964
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

BUYERS GUIDE

JOURNAL OF KENTUCKY STATE MEDICAL ASSOCIATION, FEBRUARY, 1964

Ames Company 177
Baker Laboratories 175-176
Burroughs Wellcome 110-155
Chatham Pharmaceuticals 172
City View Sanitarium 166
Coca-Cola Company 160
E. I. DuPont Company 154
Endo Laboratories 99
Fairmount Clinic 165
First Texas Pharmaceuticals 102
Heyburn Building 172
Hart Laboratories 112
The Keeley Institute 171
Lederle Laboratories 100-101-107-149-163
Eli Lilly & Company 114
Louisville Heart Association 153
J. O. Mattox, M.D. (Sale Ad) 172
Medical Protective Company 164
Mrs. A. J. Pauli 171
New Castle Sanitarium 162
Parke, Davis Company 94
A. H. Robins Company 104-105-151-167-168-169
Roche Laboratories 178
W. B. Saunders Company 95
G. D. Searle & Company 143
Smith Kline & French 113
Southern Optical Company 162
M. R. Thompson, Inc. 103
Upjohn Company 156-157
Veterans Administration 171
John T. Vie Company, Inc. 171
Wallace Laboratories 109-154-159
Winthrop Laboratories 97





Don't feel sorry for **ACETEST**® Reagent Tablet — It still does a good job. But new, improved **KETOSTIX**® "dip-and-read" test for ketone bodies in urine, serum, or plasma, is more convenient. It's faster (only 15 seconds) and more sensitive. When you use **KETOSTIX** Reagent Strips you don't even need a medicine dropper. Simply dip and read **KETOSTIX** and get a more definitive detection of ketone bodies. Still like **ACETEST** Reagent Tablets? That's okay, but remember, we said, "**KETOSTIX** Reagent Strips are more modern." □ Ames Company, Inc., Elkhart, Indiana. 69964

AMES

LIBRIUM®
(chlordiazepoxide HCl)
the successor
to the tranquilizers

ROCHE

In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment. Caution should be exercised in prescribing any therapeutic agent for pregnant patients. Supplied—Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.

MARCH 1964 • VOLUME 62 • NUMBER 3

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILA.
SEP 15 1965

In This Issue

Control of Fertility
Eduard Eichner, M.D. 195

Advances in Clinical Neurological Surgery
William F. Meacham, M.D. 200

Environmental Factors in Lung Cancer
Christian R. Klimt, M.D. 206

Bone Marrow Failure and Myelofibrosis
John A. Shively, M.D. 208

Importance of Added Humidity With Mechanical Respirators
Lester R. Bryant, M.D. 211

Complete Contents on Page 182

KSMA Interim Meeting April 23
Jenny Wiley State Park, Prestonsburg, Ky.



epilepsy may limit opportunity...



Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

extends horizons

This agent "...has brought new hope to an entire generation of seizure patients....With judicious use, it may be said that it alone is responsible for the prevention of more seizures than any other drug."*

DILANTIN (diphenylhydantoin) can help your epileptic patient to earn a livelihood...to prove his worth...and to share in the daily give-and-take as a full-fledged member of the workaday world.

Indications: Grand mal epilepsy and certain other convulsive states.

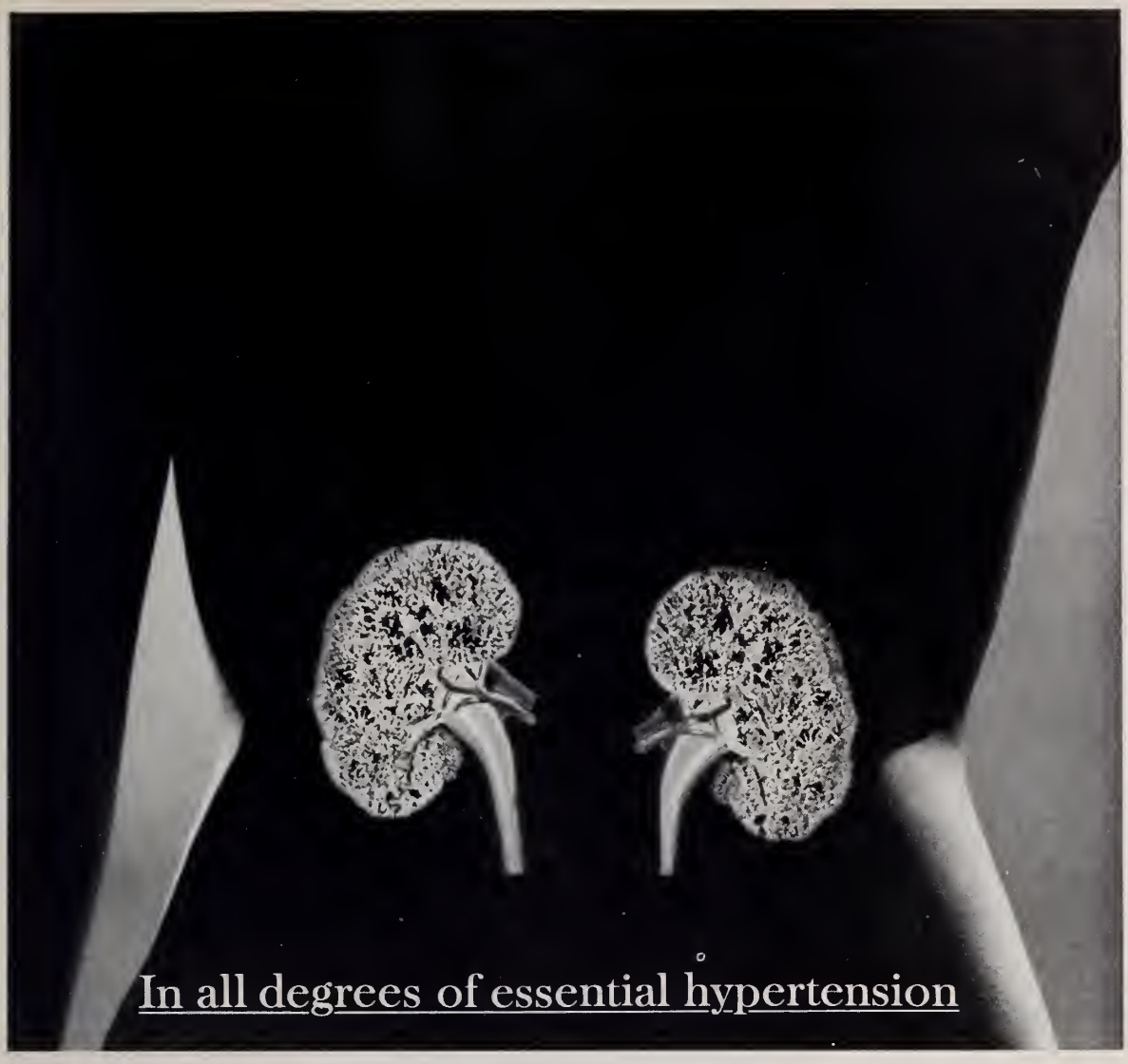
Precautions: Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia, aplastic anemia, leukopenia, granulocytopenia and pancytopenia have been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

DILANTIN (diphenylhydantoin sodium) is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm.

*Roseman, E.: *Neurology* **11**:912, 1961. 33664

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232



Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced.[1-2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality."[1] *Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients.* Rautrax-N is effective in mild,[3] moderate,[3,4] or severe hypertension.[4,5]

Dosage: Initially, 1 to 4 tablets daily preferably at mealtime. For maintenance, 1 or 2 tablets daily.

Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycosuria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin® [Rauwolfia serpentina whole root], 4 mg. Naturetin® [bendroflumethiazide], and 400 mg. potassium chloride. *Rautrax-N Modified*—50 mg. Raudixin [Rauwolfia serpentina whole root], 2 mg. Naturetin [bendroflumethiazide], and 400 mg. potassium chloride, in capsule-shaped tablets. For full information, see your Squibb Product Reference or Product Brief.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

SQUIBB
Squibb Quality
—the Priceless Ingredient
SQUIBB DIVISION Olin

RAUTRAX®-N RAUWOLFIA SERPENTINA WHOLE ROOT (50 MG.), BENDROFLUMETHIAZIDE (4 MG.) WITH POTASSIUM CHLORIDE (400 MG.), SQUIBB

VOLUME 62 • March 1964
Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Sam A. Overstreet, M.D.

• ASSOCIATE EDITOR
Walter S. Coe, M.D.

• MANAGING EDITOR
J. P. Sanford

• ASST. MANAGING EDITOR
Ann M. Huntsmon

• DEPARTMENTAL EDITORS
Jock L. Chumley, M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscar J. Hoyes, Case Discussions
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR
George F. Brockman, M.D., Chairman
Willett H. Rush, M.D.
Blaine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Moore, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES
Term Expires July 1, 1966
Harold L. Bushey, M.D.
Edward J. Fadell, M.D.
Merle W. Fowler, Jr., M.D.
Joseph L. Goldstein, M.D.
John D. Lovett. M.D.
George F. McAuliffe, M.D.
Ralph G. Thomas, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965
McHenry S. Brewer, M.D.
Lewis Dickinson, M.D.
Zygmunt Gierlach, M.D.
Douglas L. Gillim, M.D.
Arthur H. Keeney, M.D.
James B. Stith, M.D.
Chester B. Theiss, M.D.
Kearns R. Thompson, M.D.

Term Expires July 1, 1964
Herbert L. Clay, Jr., M.D.
Orville T. Evans, M.D.
M. Randolph Gilliam, M.D.
John Gordinier, M.D.
Franklin B. Moosnick, M.D.
William Oldham, M.D.
Howard W. Ripy, M.D.
Samuel M. Smith, Jr., M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205
Subscription $8.00—single copy .80
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

Control of Fertility
Eduard Eichner, M.D. 195

Current Advances in Clinical Neurological Surgery
William F. Meacham, M.D. 200

Environmental Factors in Lung Cancer: An Epidemiologist's Point of View
Christian R. Klimt, M.D. 206

Bone Marrow Failure and Myelofibrosis
John A. Shively, M.D. 208

The Importance of Added Humidity With Mechanical Respirators
Lester R. Bryant, M.D. 211

CASE DISCUSSION

Peptic Esophagitis
Herbert T. Ransdell, Jr., M.D. 213

SPECIAL ARTICLE

A Clinic For the Diagnosis and Treatment of Temporo-Mandibular Joint Disturbances
Stephen F. Dachi, D.M.D. 218

EDITORIALS

A Brighter Outlook for Mental Health 219

The Practitioner and the Full-Time Faculty Member 219

ORGANIZATION SECTION

Top Authorities Bring Medicare into Spotlight at Interim Meeting .. 222
Program, KSMA Interim Meeting 223
Unusual Entertainment Planned for Interim Meeting 224
KSMA Accepts Rare Books and Tile For McDowell Home and Shop .. 226
Heart Disease Symposium Program Plans Released 226
Industrial Medical Association Releases Meeting Program 227
Mental Health Congress Slated for May 14 in Louisville 227
Lexington Clinic Conference Offers Varied Program 230
Top KSMA-AMA Leaders to Speak at KHA Meeting 230
Kentucky Thoracic Society Plans April 23 Meeting 230
KAGP Plans Annual Meeting In Louisville May 6-8 234
Emmet Field Horine, M.D., In Memoriam 216-217

REGULAR FEATURES

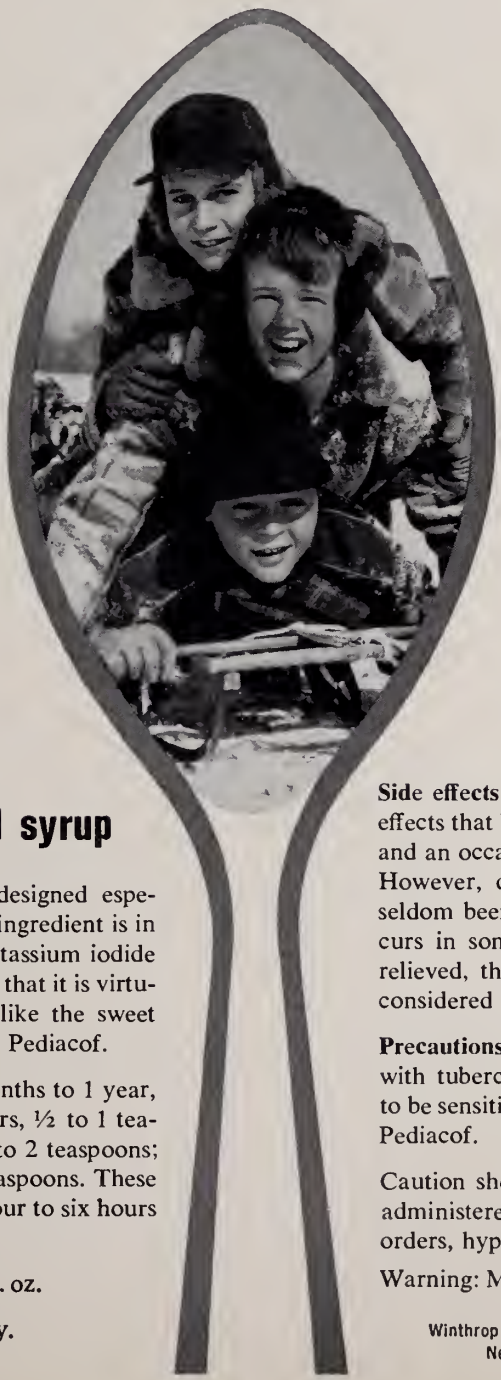
President's Page 184
Insurance Page 188
Public Health Page 192
Postgraduate Opportunities .. 238
In The Books 245
Maternal Mortality Page 252

Special cough formula for children

Pediacof®

Each teaspoon (5 ml.) contains codeine phosphate 5 mg., Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride) 2.5 mg., chlorpheniramine maleate 0.75 mg. and potassium iodide 75 mg.

soothing decongestant and expectorant



bright red, pleasant-tasting, raspberry-flavored syrup

Pediacof is different. It is designed especially for children, and each ingredient is in the right proportion. The potassium iodide in Pediacof is so well masked that it is virtually unnoticeable. Children like the sweet raspberry flavor of bright red Pediacof.

Dosage: Children from 6 months to 1 year, ¼ teaspoon; from 1 to 3 years, ½ to 1 teaspoon; from 3 to 6 years, 1 to 2 teaspoons; and from 6 to 12 years, 2 teaspoons. These doses are to be given every four to six hours as needed.

How supplied: Bottles of 16 fl. oz.

Available on prescription only.
Exempt Narcotic.

Side effects: The only significant untoward effects that have occurred are mild anorexia and an occasional tendency to constipation. However, discontinuance of Pediacof has seldom been required. Mild drowsiness occurs in some patients but, when cough is relieved, the quieting effect of Pediacof is considered beneficial in many instances.

Precautions and contraindications: Patients with tuberculosis or those who are known to be sensitive to iodides should not be given Pediacof.

Caution should be exercised if Pediacof is administered to patients with cardiac disorders, hypertension or hyperthyroidism.

Warning: May be habit forming.

Winthrop Laboratories
New York, N.Y.

Winthrop



MESSAGE FROM THE PRESIDENT

Taking A Free Ride*

IN his presidential address before the Indiana State Medical Association October 16, 1963, Maurice E. Glock, M.D., stated that about one-third of the members did all the organizational work of the Association, while the other two-thirds took a free ride.

In Kentucky we cannot boast of any better record. And those who do not participate in the organizational work probably have never considered that they are taking a free ride.

It is not an easy job to find enough good men, who will work, to take all of the committee assignments. Unfortunately some who take the assignments never do anything.

Excuses are found very easily by many. They are too busy with their practice. It is said that if you want to get anything done, take it to a busy man, for he knows how to get things done. They don't want to get into medical politics. That is a misnomer, for this is the business side of our Association.

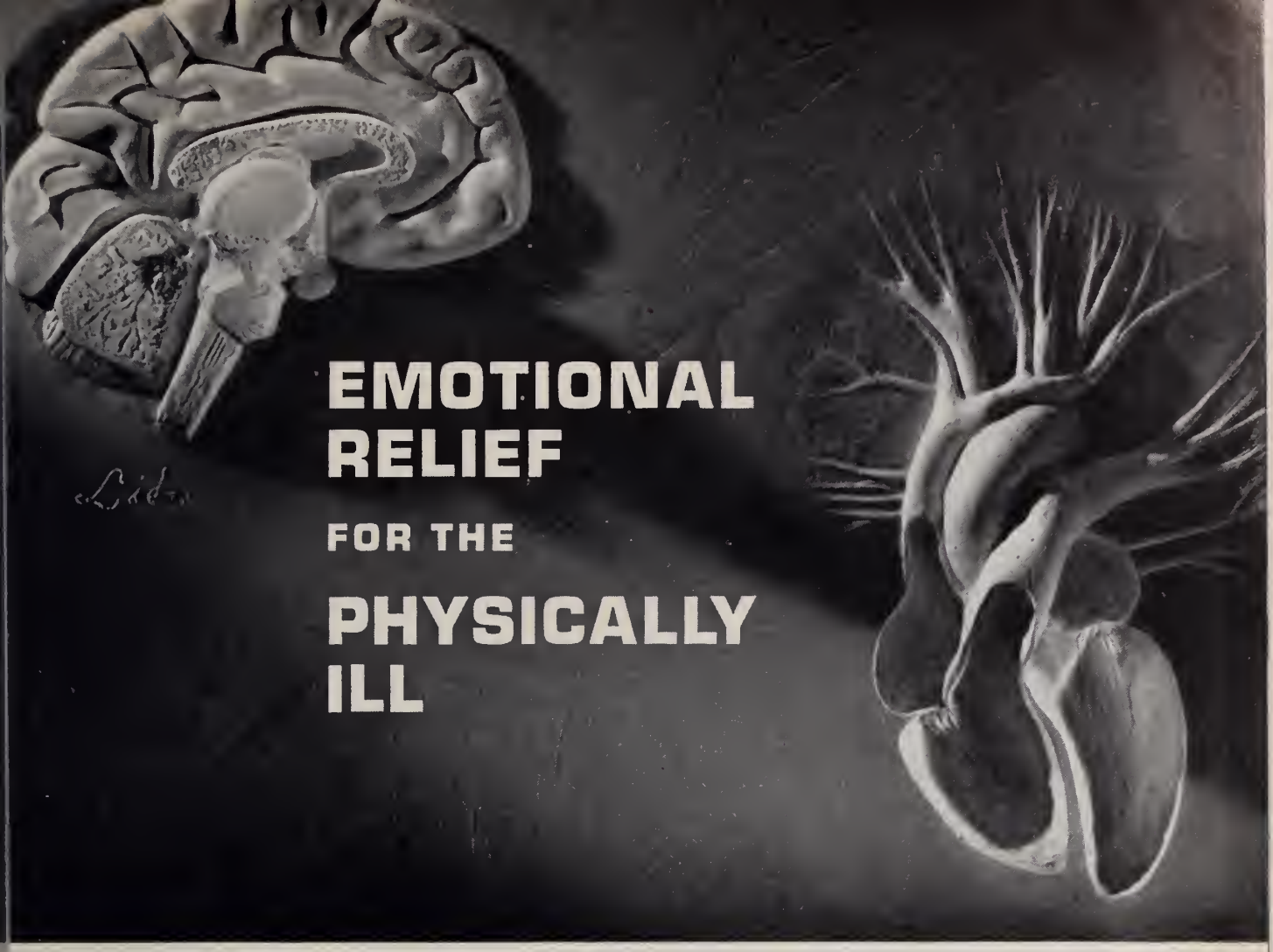
If these free riders would interest themselves in this work, they would come to a better appreciation of our problems and be more sympathetic with the solutions worked out.

Fortunately we do have a great group of interested and dedicated men who have devoted many hours of their time and traveled many miles to make the Kentucky State Medical Association what it is today.

It would be nicer if those who do not help, would not sit on the sidelines and complain about what is being done.

CARLISLE MORSE, M.D.
Vice President (Central)

This is the second in a series of guest articles written by the president of the Woman's Auxiliary and the vice presidents of KSMA at the request of KSMA president George P. Archer, M.D.



RELIEVES ANXIETY, APPREHENSION AND TENSION...



All day long
. . . keeps the patient calm, and the mind clear.



All night too
. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400
(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CME-760

WALLACE LABORATORIES *Cranbury, N. J.*



an easier way?

'METHEDRINE'® brand
METHAMPHETAMINE HYDROCHLORIDE

is an easier way to help control food craving & keep the reducer happy

With "hunger pains" abolished, the patient can shrug off the chains of psychogenic craving that bind him to his habit of overeating and cooperate cheerfully with the prescribed diet.

In obesity, "...our drug of choice has been methedrine (methamphetamine hydrochloride)...because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West. J. Surg. **59**:238 (May) 1951.

Description: Each scored tablet contains 5 mg. 'Methedrine' brand Methamphetamine Hydrochloride.

Dosage: 2.5 mg. (½ tablet) 3 times daily. May be increased gradually according to response; more than 10 mg. daily rarely is needed. The last dose of the day should not be taken later than 6 hours before bedtime.

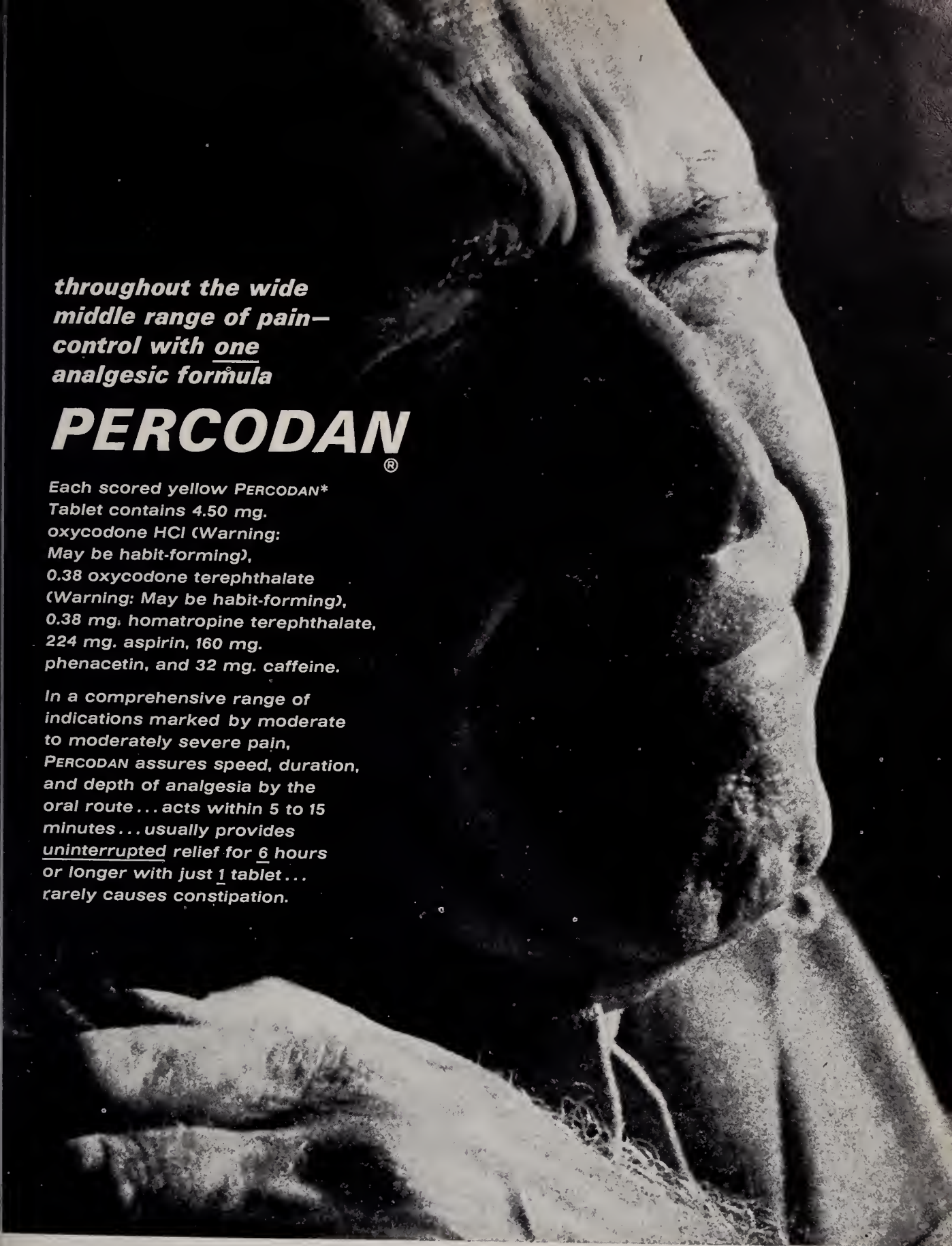
Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

Supplied: Tablets 5 mg., scored, in bottles of 100 and 1000.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



throughout the wide middle range of pain— control with one analgesic formula

PERCODAN®

Each scored yellow PERCODAN* *Tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.*

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN *assures speed, duration, and depth of analgesia by the oral route... acts within 5 to 15 minutes... usually provides uninterrupted relief for 6 hours or longer with just 1 tablet... rarely causes constipation.*

Average Adult Dose—1 tablet every 6 hours. **Precautions, Side Effects and Contraindications**—The habit-forming potentialities of Percodan are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, Percodan may cause nausea, emesis, or constipation in some patients. Percodan should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also available:** Percodan®-Demi, containing the complete Percodan formula but with only half the amount of salts of oxycodone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. **Literature on request.** **ENDO LABORATORIES Richmond Hill 18, New York**

Endo



THE INSURANCE PAGE



Sixty Percent of Aged Have Health Insurance

AT THE end of 1962, 60 percent of the total non-institutionalized aged population of the United States were protected by some form of health insurance, according to the Health Insurance Institute.

This proportion, the Institute said, represents 10.3 million persons who are 65 years of age and older protected by programs issued through insurance companies, Blue Cross and Blue Shield, and other private programs. Of this number, insurance companies insured over six million.

The Institute said that these findings for the aged are based on a survey by the Health Insurance Association of America, which has more than 300 member companies, and on figures announced by the Blue Cross Association.

At the end of 1952, the earliest year for which data are available, only 26 percent of the aged population were covered.

The Institute said that the rate of growth of persons over 65 with some form of health insurance has increased at a much faster rate than for those under 65. The proportions of persons under 65 with health insurance between 1952 and 1962, rose from 61 percent to 78 percent.

Methods employed to increase the health insurance held by the 65 and over group include use of the mass enrollment technique, and continuing group coverage for persons after they retire.

The Institute said that over 200 companies are actively issuing health insurance programs for the aged. According to a recent Institute study, four out of five workers covered under group policies issued by insurance companies during 1962 offered employees the right to retain their coverage upon retirement by conversion or continuation.

The mass enrollment programs which are open to all applicants without medical examinations, fall into two categories: (1) those offered in a particular region or even nationally by a single company, and (2) those offered in a single state by a pool of companies.

Most active in the former area have been the Continental Casualty Company, Chicago; Mutual of Omaha; and Fireman's Fund Insurance Group, San Francisco. In the latter area are the Connecticut-65, Massachusetts-65, New York-65, and Texas-65 plans. Western-65 is expected to get underway in California early in 1964.

Most Blue Cross and Blue Shield organizations also provide health insurance to the aged through special programs, in addition to continuation of coverage held prior to age 65.

In 1963, the following states passed legislation permitting companies to pool their resources and offer state residents mass enrollment coverage: California, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Virginia and Washington.



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective **GERIATRIC** antiarthritic with

REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate-SF

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium para-aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe PABALATE-SODIUM FREE

Butazolidin®
brand of phenylbutazone

Tablets of 100 mg.

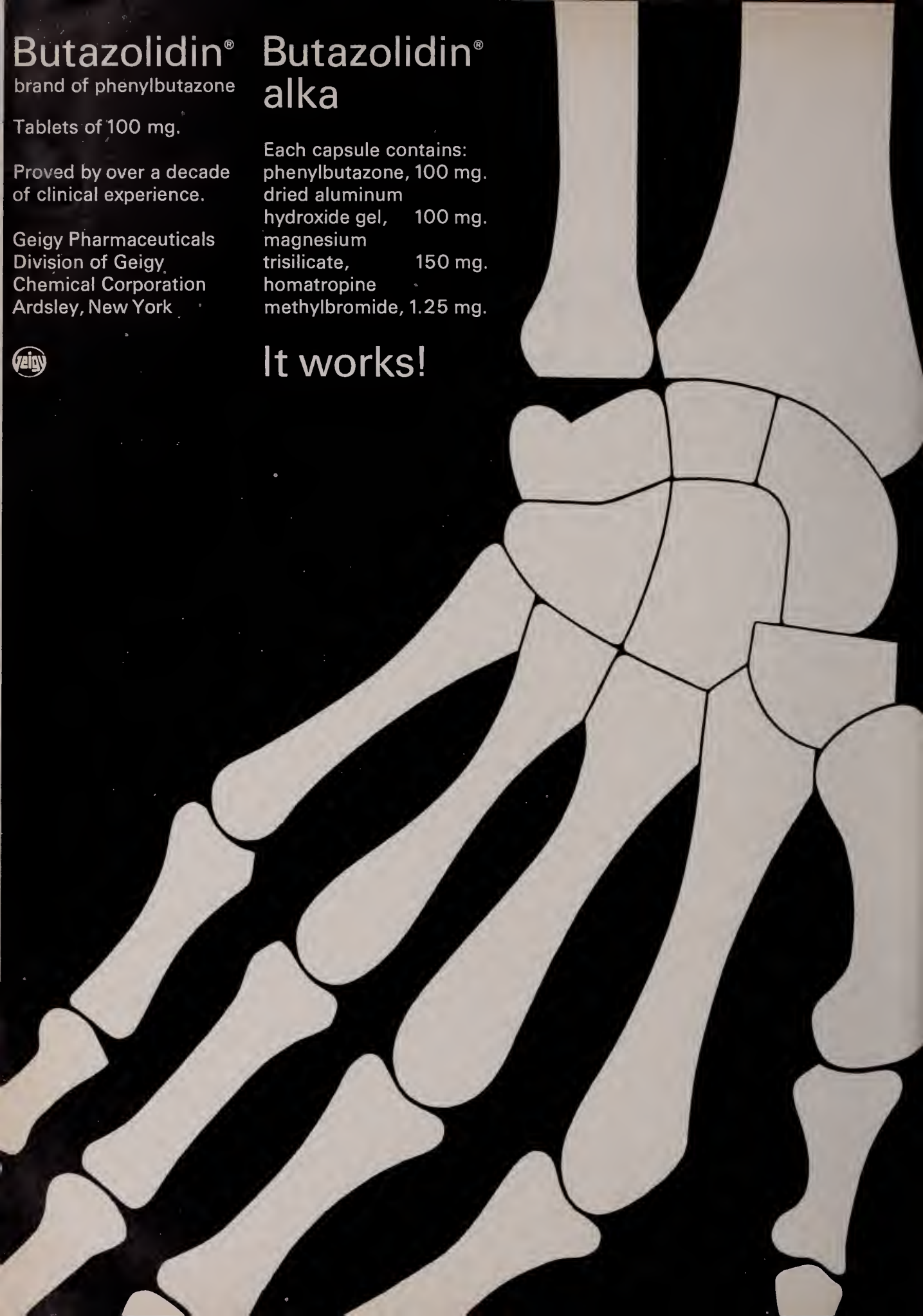
Proved by over a decade of clinical experience.

Geigy Pharmaceuticals
Division of Geigy
Chemical Corporation
Ardsley, New York

Butazolidin® alka

Each capsule contains:
phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

It works!





SERENE SURROUNDINGS

ACCREDITED PSYCHIATRIC HOSPITAL FOR PRIVATE DIAGNOSIS AND TREATMENT

Approved by the Joint Commission on Accreditation of Hospitals.

Equipped to provide latest acceptable methods of treatment, including Out-Patient Pavilion.

Ample classification facilities with qualified psychiatric nursing.

Full recreational therapy facilities.

Forty acre estate to assure privacy in a restful setting.

Brochure and rate schedule available on request

CHARLES W. MOCKBEE, M.D.
Acting Medical Director

ISABELLE DAULTON, R.N.
Director of Nursing

GRACE SPINDLER, R.N.
Associate Director of Nursing

ELLIOTT OTTE
President and Chairman

CHARLES M. CLIFFE
Business Administrator



THE EMERSON A. NORTH HOSPITAL, Inc.
(Founded 1874)

5642 HAMILTON AVENUE, CINCINNATI 24, OHIO
Telephones: 541-0135, 541-0136

PUBLIC HEALTH PAGE

The Kentucky Vaccination Assistance Project*

RUSSELL E. TEAGUE, M.D., M. P. H.
Commissioner of Health
Commonwealth of Kentucky

A VACCINATION Assistance Project, which is planned to raise the level of protection in Kentucky's population particularly in pre-school children, against four serious diseases, diphtheria, whooping cough, tetanus, and poliomyelitis, is being developed by medical societies and health departments.

The Kentucky plan to protect against these diseases provides assistance to counties to conduct intensive vaccination programs in their communities. Assistance to counties is provided through county health departments, and consists of vaccines and services. The plan is based on a cooperative effort of practicing physicians, State and county health department, voluntary organizations and volunteers to immunize unprotected persons in every county.

We are stressing the importance of immunizing children under five years of age, and hope to set up an effective on-going program to ensure the immunization of infants. Under the plan, free vaccines are being made available to counties to provide immunizations for children under the age of five years against these four diseases.

An education program is planned to urge the necessary immunizations, and to attract all susceptible persons to the offices of practicing physicians and community facilities for them. Local plans will be worked out in each county through the physicians, the county health department, and other interested groups.

The Medical Advisory Committee to Kentucky's project, composed of representatives of the Kentucky State Medical Association, the Kentucky Academy of General Practice, the Kentucky Academy of Pediatrics, and the College of Surgeons, has endorsed the project. In their endorsement statement, members of the Medical Advisory Committee pointed out that in spite of the fact that we have effective vaccination against diphtheria, whooping cough, tetanus, and poliomyelitis, not all susceptible children and young adults have taken advantage of opportunities for protection against complications or death resulting from these diseases. They recommended that all Kentucky physicians participate in, support, and encourage this joint project for raising vaccination levels in these poorly protected and susceptible age groups.

Kentucky has received a federal grant under the Vaccination Assistance Act of 1962 to assist in this program for the first year. It is anticipated that additional grants will be given for an additional two years. Grant funds will be used to purchase vaccines for children under five years of age, and to provide personnel for planning, education, and promotional activities, and to help with laboratory studies.

**This article was prepared by Donald B. Thurber, M.D., Office of Local Health, Kentucky State Department of Health, Frankfort, Kentucky*



After Surgery: B and C vitamins are therapy

Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS, designed to meet increased metabolic demands, aids in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

STRESSCAPS®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

7292-4



THESE STAINLESS-STEEL PINS TAKE ON THE APPEARANCE OF TINY FLAMING CANDLES BECAUSE OF THEIR HIGH POLISH.

This pin is 0.00032 of an inch larger than perfect. As a result, it is rejected. ■ Stainless-steel pins like this are used to mold Lilly capsules. From each tray of three hundred new pins, fifty are selected at random. The diameter, length, taper, contour, and finish are carefully measured. If the sensitive electronic measuring devices show an imperfection beyond the hairsplitting limits, the entire tray of three hundred is rejected. ■ Lilly quality control draws the line at ± 0.0003 of an inch for some dimensions and ± 0.0005 of an inch for others. A split hair can mean the difference between perfection and rejection . . . another of the many important controls that add immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U. S. A.

Lilly

400169

The JOURNAL of the
Kentucky State Medical Association

Issued Monthly Under the Direction of the Board of Trustees

VOLUME 62 MARCH, 1964 No. 3

Control of Fertility†

Eduard Eichner, M.D.*

Cleveland, Ohio

A brief review of the mechanism of action of contraceptive drugs is followed by an analysis of over 1200 "safe" cycles.

THE first control of ovulation by ovarian steroids was accomplished by the use of impure conjugated estrone. Eventually satisfactory inhibition was accomplished by stilbestrol, the synthetic estrogen which most effectively suppresses the production of pituitary gonadotrophins. Because of side effects inherent in the use of estrogens (primarily nausea and bleeding) other methods were investigated. Progestogens were next. Since pure progestational compounds require the use of a concomitant estrogen, oral progestins which either had an accompanying estrogenic effect or which contained added estrogen were tried. Newer concepts are now being investigated and these will be presented briefly later.

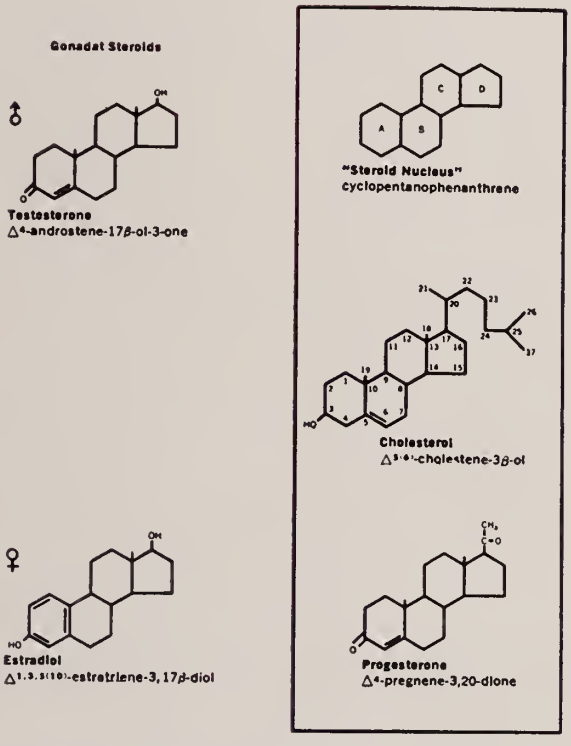


FIGURE 1. The steroid nucleus, and the relation of the formula of cholesterol to the potent gonadal steroids.

Chemistry

Because of the varied steroid terminology I wish to spend a brief moment or two on hormone identification. The steroid formula consists of 17 carbons arranged in a four-ring compound. The rings are labelled "A" through "D" respectively, and the carbons occur at each angle. Their numbering follows the configuration of a "Lazy S", for those who read the Westerns. The projecting angular lines usually infer an attached methyl (CH_3) group if no lettering is present. (Figure 1). Cholesterol with its 27 carbons is pictured. By removing

† *Presented at the 12th Annual Assembly of the Kentucky Academy of General Practice held at the Kentucky Hotel in Louisville May 8 - 10, 1963.*

* *From the division of Obstetrics and Gynecology at Mount Sinai Hospital in Cleveland, Ohio*

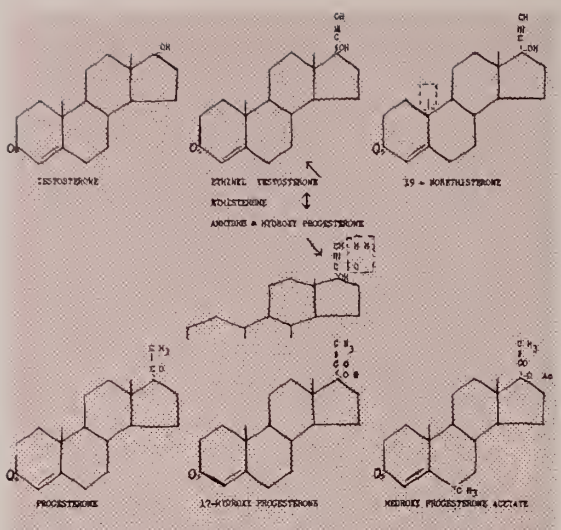


FIGURE 2. The structural relationship between testosterone and progesterone derivatives.

carbons 22 through 27, the remaining 21 carbon steroid is either a corticoid or a progestational drug. The former usually has an oxygen at carbons 21 and 11, if a functioning corticoid. If the 20 and 21 carbons are now removed, the residual product is an androgen. This is what occurs in the body when cortisone or precortisone derivatives are excreted as 17-ketosteroids. The same type of event occurs in the adrenal genital syndrome when there is an enzymatic block which prevents the formation of hydrocortisone.

Further reduction in the molecule by removing the 19 carbon produces an estrogen. Although all natural estrogens have a phenolic A ring, at least in part, and all androgens have either a saturated A ring, or are unsaturated at carbon 4, the mere presence of 18 carbons in the 19-nor compounds (absence of the 19-methyl group) is taken, not always correctly, to signify an estrogenic compound. In routine metabolism of many of these compounds the human body can shift the unsaturated bonds relatively freely in rings A and B.

The route of conversion of testosterone to progestational drugs is shown in Figure 2. Please note that the loss of water at the 20 and 21 carbons of 17-hydroxyprogesterone converts it to anhydrous hydroxy progesterone, isomerically identical with ethinyl testosterone, otherwise known as ethisterone, the first oral progestational compound. The next formula is a 19-nor compound more familiarly known as Norlutin®, and it is the progestational ingredient of OrthoNovum®. By switching the double bond 4-5 to 5-10 (the body does this with ease) the new product is the active progestogen in Enovid®. The lower line of formulas show the transfer of progesterone to medroxyprogesterone acetate (MPA or Provera®), a compound which has only progestational activity. This with added ethinyl estradiol, a very potent estrogen, is the product I will discuss. It is called MPA-EE, or Provest®.

Mechanisms of Action

Thus far only the suppression of ovulation, supposedly by pituitary inhibition, has been mentioned as a means of control of conception. Those who read the papers are well aware of the west coast experiment which interfered with spermatogenesis and also destroyed libido. This last was too much for the masculine ego, but this type of study is continuing. Also we have been made cognizant of the possibility (please note I did not say "probability") of continuing fertility into the geriatric age. These and other supposedly adverse possibilities have led to investigation of other means short of continence for the control of fertility. These involve the failure or interference with the various key mechanisms in the female from ovulation to nidation.

Pituitary failure to stimulate ovulation may result in failure of follicle development (FSH), or by failure of follicle maturation (LH). The exact target, or the actual presence of human LTH has not been evaluated. Assuming adequate and proper pituitary activity, ovulation may still be improper if the ovary fails to react to its stimulus. Another method of failure which involves the ovary is its inability to secrete adequate amounts of estrogen and progesterone at the proper time of the cycle. The ability of sperm to penetrate cervical mucus depends on the character of this mucus, which ideally should be under the influence of peak estrogens. Excesses of progesterone interfere with this process, and this too may be one of the methods by which progestational drugs inhibit the process of conception.

Smooth muscle responds to various hormones, and it is likely that some drug will be developed which will interfere with tubal transport of the sperm to the egg or the fertilized ovum to the uterus. A delay in either direction at the critical time could prevent the development of pregnancy. The developing blastocyst might run out of nutrition before nidation

could occur, or there might even be failure of blastocyst formation.

Assuming proper development and transport, the last method of preventing pregnancy would be failure of nidation. This might be accomplished either by preventing decidual formation or by so speeding the decidual development that the optimal time for nidation is passed. The former is one of the effects of estrogen, the latter is a progestogen result. Chemically, carbonic acid anhydrase inhibitors interfere in some species with the production of carbon dioxide at the junction of the burrowing trophoblast, and thus prevent nidation. Other similar processes may be discovered.

Lastly, because of the fear that the progestogens produce endometrial atrophy, decidual casts and other abnormalities, the concept of sequential therapy is again taking hold. This consists of an estrogen for the first half or two-thirds of the cycle followed by a potent progestogen for approximately five to seven days. This produces the well known "medical curettage" with an adequate slough of a well-primed endometrium. This technic is as effective as the full course of progestational drugs, may be cheaper, but in my experience has failed to answer completely the problem of nausea caused by estrogens.

The Progestogens

Since side effects of estrogens were not readily controlled, and since continued use required increasing dosages, attention was finally turned to the progestogens. The first ones had several undesirable side effects, and further study was undertaken to alleviate these. There are many drugs under current investigation, but the remainder of my presention will be limited to the previously described MPA-EE, which now contains 10 mg. of medroxyprogesterone acetate and 0.05 mg. ethinyl estradiol per tablet. Estrogen is added since MPA is a pure progestogen and requires the presence of estrogen for its effectiveness. Various combinations of these compounds were tried originally, and the dosage schedule varied from 20 to 25 days, usually starting on the fifth day of the current cycle, and seldom more than one week after discontinuing medication during the preceding cycle. The 20-tablet schedule usually gives a cycle of about 26 days, although the cycle of almost all patients did increase to 28 days after several months of treatment. Many women preferred the 25-tablet schedule since this decreased the number of yearly cycles from 13+ to slightly less than 11.

	Cycles Studied†							
Cycles:	1-6	7-12*	13-18	19-24	25-30	31-36	Totals	
							Patient	Cycles
Continuous Treatment Group	1	7	14	4	5	2	33	571
Treatment Discontinued Group	42	19	7	4	1	1	74	566
Grand Totals	43	26	21	8	6	3	107*	1137

* One patient included twice, once in each group

† Previously presented at Brook Lodge Conference on Provest, February, 1963.

TABLE 1. The number of cycles studied.

Patients with rather long original cycles occasionally needed added MPA for control of breakthrough bleeding, whereas women with very short cycles had their medication started on the second or third day of the new cycle to prevent bleeding. Extra medication (MPA) could often be reduced or discontinued in these patients after two to four months of control. In the recent puerperium, contraception medication was often started before the onset of the first natural menstrual period at six to ten weeks. Control was usually complete within three months. Several patients continued to nurse satisfactorily for several months after starting Provest, and there was no difficulty in discontinuation of nursing when desired. Galactorrhea was not present.

Results of Study

As of January 1st, 1963, 106 patients had participated in over 1100 cycles without concurrent pregnancy. Seventeen have been on the study over 18 months, and three have been on over 31 months (Table 1). These numbers are slowly increasing although there have been no new additions to the investigation. Seventy-three have dropped from the experiment, and the reasons are given in Table 2. It is noteworthy that less than 10% complained of bloating or breast congestion, and that many of those who stopped treatment because of bleeding did so in the very early phases when there was a lack of knowledge of the optimum dose.

It is evident (Table 3) that those desiring early conception did so with dispatch. Delay occurred only once. The patient with a two-month delay and one of the others was asked

Primary Reason for Discontinuation of Medication		
Personal Reasons:		26
no explanation	14	
moved	4	
newspaper scare	2	
can't take tablets	5	
religion	1	
Irregular or prolonged bleeding		19
Desired pregnancy		12
Intervening operation (sterilizing 4, appendectomy 1, thyroidectomy 1, anal fissure 1, husband sterilizing 1).		8
Bloating/breast congestion		6
Tiredness		4
Growth of uterine fibroids		3
Headaches		1
Accessory Reasons:		
headaches	3	
rash	3	
endocrine experiment	3	

TABLE 2. Primary reasons for discontinuation of medication.

Summary of Patients Treated Over 18 Months*		
# Pts.	Age	Parity
17	23-47	0-6

Reasons Medication was			
Started		Discontinued	
Contraceptive control	13	Desired pregnancy	3
Dysmenorrhea	3	Desired "rest"	1
Menorrhagia	1	Postoperative withdrawal	1
		Requires operation for post-conization cervix	1
Troublesome Symptoms			
Tiredness	4	Headache	5
Bleeding	3	Depression	2
Eczema	1	Dysmenorrhea	2
Indigestion	1	Amenorrhea	1
Completely Asymptomatic			4

*Previously presented at Brook Lodge Conference on Provest, February, 1963.

TABLE 4. Summary of patients treated over 18 months.

to avoid pregnancy until the first normal period had occurred. In the group who discontinued treatment for all other causes, and who later became pregnant, the average delay in the onset of pregnancy was just over six months. All infants were normal, and there was no preponderance of either sex. One neonatal death resulted from hyaline membrane disease secondary to immature delivery at 30 weeks after several weeks treatment for spontanous premature ruptured membranes.

One patient has had two spontaneous abortions after treatment but she has only one living delivery out of seven pregnancies. One patient had a probably induced abortion, and there was a spontaneous abortion in a subject whose medication was discontinued when

Pregnancies After Conception Control										
Desired Immediate Pregnancy										
Control cycles	27	17	16	12	12	7	7	5	5	4
Months: control to pregnancy	0	6	0	1	1	0	1	0	2	1
Delivery	-	-	F	M	X	M	-	M	F*	F
Intervening Second Method										
Control cycles	19	12	11	8	7	6	3	3	2	1
Months: control to pregnancy	10	5	6	1	9	3	8	6	6	7
Delivery	-	F	-	-	X	M	M	F	X	-

M = Male F = Female X = Miscarriage * = Neonatal Death - = Undelivered at May 1, 1963

TABLE 3. Pregnancies developing after conception control.

growth of uterine fibroids occurred. Her nonpregnant uterus now contains fibroids ranging up to 7 cm. in diameter. As a result of growth of leiomyomata in the early phases of this study patients with tumors over one inch in diameter are not placed on this type of therapy. None of the newer patients with fibroids have had any difficulty.

The course of the patients who have been on the study over 18 months is summarized in Table 4. Six of the 17 patients discontinued treatment after 18 months, only one because of difficulty. She has a post-conization (carcinoma in-situ cervix) stenosis which requires frequent dilatation. Malignancy has not recurred, but persistent spotting and cramps were considered by the patient as the result of drugs. However, symptoms have continued even though there has been no medication for over six months. One withdrew from the study when it was publicized that patients should not be medicated over two years. She stopped after her 31st cycle. Those desiring pregnancy did so with ease, and one withdrew after a serious operation.

Among the troublesome symptoms, tiredness and headaches led the list. The one patient with eczema was proven not to have a drug sensitivity. One patient developed prolonged and worrisome periods of amenorrhea, but assurance of the absence of pregnancy kept her on an even keel emotionally.

In the preliminary studies on this drug, it was determined that it was (and is) an effective

oral contraceptive. Estrogen was not needed for inhibition of ovulation (Table 5) as both the oral and injectible MPA satisfactorily prevented either the production or excretion of pregnanediol. Its absence in the urine during the second half of the menstrual cycle was taken as evidence of the failure of ovulation. Of course, the MPA-EE had a similar effect.

Several groups of patients were also tested in regard to the effect of this compound on adrenal activity. MPA did not suppress the adrenals, nor did it prevent the usual adrenal response to injected corticotrophin. In one young subject with early Cushing's syndrome, medroxyprogesterone acetate had no effect on the patient's excretion of 17-ketosteroids or 17-ketogenic steroids. The substitution of prednisone for Provera reduced both of these excretion products to within normal range.

Conclusions

The chemistry and relationship of some of the progestational drugs is presented, and the varied methods of meeting the problem of conception control by drugs is discussed. The use of cyclic medroxy progesterone acetate with added ethinyl estradiol for the prevention of ovulation is presented. Tables demonstrate the proof of the failure of ovulation after use of these tablets, the failure of interference with normal adrenal activity, and the paucity of serious side effects.

No unwanted pregnancy occurred in any of the 106 patients, and the use of this drug did not intrefere with the rapid occurrence of a desired pregnancy after withdrawal from the study. There were no abnormal infants, and toxic or undesired effects with the use of MPA-EE were minimal. Several patients have been on the study for over 36 cycles at the present time. Spontaneous menstruation may be delayed two or more weeks during the first cycle after discontinuation of treatment, to return promptly to the pretreatment cyclic regularity. Provest is apparently a safe and well-tolerated drug for use in the prevention of undesired pregnancy.

Urinary Pregnanediol Determinations—Mg./24 Hrs.
Medication Started on Day 5

		Day 8	Day 22
Provest tablets 1+ tab. daily, 25 days	(11 patients)	0.1 - 2.6	0.2 - 1.6
First cycle after discontinuation Rx.	(3 patients)	0.6 - 1.3	9.1 - 11.2
Provera 10+ mg. daily, 25 days	(4 patients)	0.1 - 2.6	0.6 - 2.8
Provera 50 mg. injected I.M. day 5	(5 patients)	0.7 - 2.8	0.7 - 4.9*

*Possibly the result of interfering provera chromagens

Urinary Corticoid Determinations

Mg./24 hours — Day 22

Routine	Medication		17-KS	17-KGS	17-OHCS
A	Oral Provera 10+ Daily	(3 patients)	3.4 - 16.5	6.0 - 12.2	4.0 - 4.3
B	Injectible Provera 50 mg. I.M. day 5	(1 patient)	10.8	12.5	
C	Provest Oral 1+ tablet daily with				
	80 IU ACTH gel. I.M. on 15-20th day	(14 patients)	pre-ACTH	4.8 - 23.1	(median 10.2)
			post-ACTH	8.3 - 41.0	(median 19.5)

Increase ranged from −3.3 mg./24 hrs. to +27.9 mg./24 hrs. (median increase 77.5%)

17 year-old with early Cushing's syndrome

Control	13.2		20.4
A	12.2		21.6
20 mg. daily Prednisolone	12.9	1st month	14.8
	5.9	10th month	11.3

TABLE 5. Urinary steroid excretion studies.

Current Advances in Clinical Neurological Surgery†

William F. Meacham, M.D.*
Nashville, Tenn.

Improvement in medical technology has resulted in the use of many new diagnostic and therapeutic technics in the field of neurologic surgery. The practical aspects of many of these methods are presented, even though some are hardly beyond the experimental stage.

In an age of technological advances which have enabled man to orbit the earth and to anticipate successful interplanetary travel, it is paradoxical that so many fundamental aspects of medicine remain in limbo. In my own specialty of neurological surgery, we cannot, after fifty years of intensive clinical experience, claim a victory over the mundane, garden-variety infiltrative glioma; nor can we repair the damaged spinal cord, or even predict with any certainty the recovery of a divided peripheral nerve. However, it is obvious that we have not remained in hibernation, for a vast amount of research and clinical study has brought many rewards in our practice, even though a solution to some of our most basic problems has not ensued.

In the exciting, formative years of neurological surgery, the technics were developed for safe access to the intracranial and intraspinal compartments. They have stood the test of time and are, in general, the basic methods in use today. Probably no single discovery since then can compete in importance with Dandy's description of the use of air in contrast studies (pneumoencephalography and ventriculography). This valuable adjunct to diagnostic neurology has been constantly employed since 1918. Nevertheless, there remain certain drawbacks to its use—namely, the inherent dangers of spinal air injection in the presence of increased intracranial pressure, the frequent failure of adequate ventricular filling, the rather disturbing esthetic property of direct ventricular injection, and the necessity for prompt definitive surgery after disturbing the carefully balanced intracranial adjustments following the air injection. For these reasons, it has been desirable to find a method of intracranial localization that will be dependable and efficient and avoid the undesirable features enumerated above. Unfortunately, this yet remains to be done, but probably the use of opacification of the intracranial vessels most closely approaches the ideal.

Angiography and Other Techniques

Carotid and vertebral angiography has enjoyed increasing employment with numerous refinements in technic. Used at first only in the diagnosis of suspected intracranial aneurysms, it was soon obvious that the recognition of vessel displacement, abnormal circulation of tumors, and compression of brain from extracerebral causes (subdural hematoma) could be detected with a high degree of accuracy. With the use of cine technics, the angiogram can be re-run and studied at slow speeds offering some advantage over the multiple exposure system usually employed. Variations in the technic of injection are currently being evaluated (retrograde brachial, subclavian, massive intravenous, etc.) in addition to the standard percutaneous carotid or vertebral puncture.

Due to certain inherent risks associated with angiography, attempts are being made to improve the chemical substances used for contrast by giving better opacification and at the same time reducing the chemical insult to the vascular bed of the brain and the blood-brain barrier. As this is being accomplished, reactions

† *Presented as the Annual Oration in Surgery before the Transylvania Medical Society meeting held in Louisville on April 25, 1963*

**Clinical Professor of Neurological Surgery, Vanderbilt University School of Medicine, Nashville, Tenn.*

and complications are becoming less frequent and less severe. Unfortunately, there remain certain "blind spots" within the cranium that may harbor space-occupying lesions and not be disclosed by standard angiographic routines and require the use of other methods of detection.

The use of some contrast material other than air has been long sought for better ventriculographic demonstration. Pantopaque®, Thoratrast®, and Conray®, all compounds with marked radio-opaque properties, produce ideal contrast, but unfortunately, are associated with far too many unfavorable reactions to allow their routine use. The best of these, at the moment, is certainly Pantopaque which seems to produce little or no inflammatory response from the ependymal lining of the ventricles, but is productive of marked chronic inflammatory changes when it remains in contact with the arachnoid, according to our long term studies on the experimental animal.

Neurosurgery has also profited from the use of radioisotopes. Mercuhydrin® or Risa® given intravenously may appear in certain tumors in such heavy concentrations that the radioactive emissions over the tumor site will be much denser than over the remaining cerebral tissues. When counted by a mechanically moving, automatic counter and printed on paper or exposed on X-ray films, a "picture" of the tumor can be obtained. This process of "Brain scanning" is proving highly successful when performed with mechanically dependable equipment and may approach 80% to 90% accuracy in the localization of supratentorial tumors or encapsulated abscesses.

The familiar and routine surface recording of electrical potentials from the brain with the standard electroencephalographic technic has been a diagnostic tool for many years, but with severe limitations as far as dependable localization of space-taking lesions is concerned. In unusual diagnostic problems, the EEG effectiveness has been enhanced by using multiple, fine wire electrodes introduced into the cerebral tissues allowing continuous and intermittent recordings throughout the 24 hour period. Such depth electrode recording has proven to be a valuable research tool in the human.

Therapy

Progress in the therapy of craniocerebral trauma has been accomplished by a rather laborious method. Obviously, the recovery from traumatized brain parenchyma can occur only with time and with the inherent recovery capabilities of the individual. However, further insult to already damaged tissues can be minimized by several methods now in current vogue.

The use of solutions of urea or mannitol to reduce brain swelling with a minimum of "kick-back" reaction is very helpful, although integrity of renal and circulatory status is necessary for their use. The same effect may be obtained with the use of high-potency steroids such as Decadron® over a more prolonged period, but the immediate effect is less dramatic. Similarly, in the comatose patient, reduction of the intracranial pressure may be affected by controlled hyperventilation respiratory activity using a mechanical respirator with intratracheal or tracheostomy tube. In this connection, it is important to commend the widespread recognition of the value of tracheostomy in the care of the acute, severely brain injured patient. Nothing is more dangerous than imperfect respiratory exchange and in such patients, prompt and effective relief of mechanical respiratory dificulties can be obtained with tracheostomy.

Increased appreciation of the value of hypothermia has given the neurosurgeon an opportunity to employ refrigeration technics in the treatment of acute brain injuries. By reducing the metabolic requirements of the cerebral tissue with the maintenance of subnormal temperatures, cerebral swelling is minimized and, theoretically, damaged tissue with questionable viability may be afforded a better chance of survival. Furthermore, the distressing hyperthermic responses so frequently seen in such patients are obviated. It is indeed gratifying to see the decerebrate state disappear in many patients so treated.

Cranial injuries resulting in loss of substance of dura and skull may be easily repaired with lyophilized human cadaver dura or quick-frozen dural grafts from a "dural bank." Fibrin film or thin sheets of polyethylene may be used as readily available dural substitutes. It is now our practice to replace large bone fragments following repair of comminuted depressed fractures and, in every instance, satisfactory and firm union has occurred, thereby obviating the necessity for later cranioplasty. However, where bone is irretrievably lost, or in contaminated wounds, the cranial defect can be easily

repaired at a later date with a well fitting plastic substitute (methyl methacrylate) tailored at the operating table. Where large bone flaps must be removed for decompressive purposes, they can conveniently be left in the deep-freeze and replaced with perfect re-healing as long as twelve months later. In our series not a single infection or rejection of the frozen bone flap has occurred.

Fractures through the base of the skull with associated dural tears resulting in cerebrospinal fluid fistula can be sealed with acrylic resin compounds as an adjunct to the surgical cure of the fistula.

Like Humpty Dumpty, the damaged spinal cord cannot be put together again, albeit new and ingenious methods of phyiscal rehabilitation offer great promise of increased usefulness to the paraplegic. Anterior spinal fusion with interbody bone grafts helps in early ambulation of the non-paralyzed victim and certainly allows for earlier rehabilitation measures in the paraplegic thus avoiding long periods of bedfastness while waiting for spinal stabilization. In simple fracture dislocations of the cervical spine, the use of the Minerva jacket in conjunction with a cranial "halo" fixed into the outer table of the skull has allowed immediate ambulation and maintenance of reduction throughout the entire recovery period.

Of particular interest to the paraplegic patient is the development of a small transistorized unit implanted subcutaneously with the fine electrodes leading to the bladder wall that can be triggered by radio waves to cause bladder contractions at specified intervals. Employed successfully in the experimental animal, it has now been used with some success in a small number of human cases.

Surgical attempts to restore function in the spinal cord segments below a point of focal damage have not been successful. Transplantation of intercostal nerves into the spinal cord for regeneration purposes has a high theoretical value, but on practical grounds no laudatory results have been obtained from this speculative procedure. However, such work certainly can be the basis for continued interest in elevating the chronic paraplegic from "back-ward" status.

Intracranial Vascular Disease

At no time have contemporary neurological surgeons been involved in so difficult a task as now confronts them in the problems associated with intracranial vascular disease. Never before have the human carotid arteries enjoyed such a sustained surgical popularity! On the one hand, we are confronted with the problems of preventing cerebral ischemia and vascular insufficiency by reconstituting the lumina of arteries partially or wholly occluded by sclerotic plaque or thrombus. On the other hand, we are constantly trying to efface the lumen of one artery or another to obviate a possible demise from a ruptured aneurysm. To be candid, we have no reliable way to make arteries patent or prevent hemorrhage. However, this is not to say that rewarding and salutary results cannot be obtained. But we should remember that after more than a decade of intensive operative experience, no one can state without fear of contradiction just how, for instance, a specific intracranial aneurysm can best be handled. In many areas, the Hunterian operation, once discarded, has been employed for all bleeding intracranial aneurysms.

In our own clinic, we have not regularly employed the principle of proximal artery ligation, feeling instead that a direct attack upon the lesion itself is preferable. This philosophy, however, is sorely beset with a galaxy of brilliant successes, gloomy vicissitudes, and dismal failures. To improve the score, a massive array of surgical gadgets, clips, postures and positions, methods of exposure, and technics of management has filled the programs of our scientific societies.

Choice of Treatment

The neurosurgeon today can take some comfort from a variety of therapeutic choices, selecting a method of treatment from among the generous assortment listed below (any of which may be correct):

1. Medical treatment (limited activities, supportive and symptomatic care).
2. Ligation of the common carotid artery.
3. Ligation of the internal carotid artery with The Selverstone or Crutchfield clamp (slow, progressive occlusion).
4. Intracranial clipping of aneurysm under normothermic conditions.
5. Intracranial clipping of aneurysm with hypotension.
6. Intracranial clipping of aneurysm with hypothermia.

7. Intracranial clipping of aneurysm with profound hypothermia and extracorporeal shunt
8. Intracranial clipping with regional hypothermia using artery-vein shunt with heat exchanger
9. Intracranial clipping with local hypothermia (stream of cold Ringer's Solution)
10. Reinforcement of aneurysm with muscle or with plastic coating
11. Injection of hog bristle into aneurysmal sac to promote thrombosis

Undoubtedly, the method of greatest promise will be that method used by the surgeon until he masters it. One day, this obviously controversial issue will be settled, but for the time being, each neurosurgeon must resolve this issue by carrying out the plan of treatment in which he has the greatest skill and confidence. At the moment, I suggest that this same attitude prevail in the management of the clinical syndromes designated as "vascular insufficiency."

Tumors

When W. W. Keen of Philadelphia first successfully removed a brain tumor in 1888, who would then have thought that 75 years later, after thousands of similarly successful operations, the problem of the ordinary infiltrating glioma would not be solved? Nevertheless, this is true. In spite of the most radical surgical attempts, including removal of the entire hemisphere, in most gliomata, only palliative effects are obtained, although in some slowly growing gliomata, the palliation extends for years. We, therefore, look hopefully to the enzyme chemist, the molecular biologist, and the radiation physicist for some discovery to effectively stay the progress of these dreadful lesions. Thus far, the effects of perfusion of the brain with chemotherapeutic agents and anti-metabolites has not been fruitful.

The promise originally expected from high-potency radiation has likewise not been fulfilled. Betatron therapy and other methods of radiation treatment have not produced consistently rewarding clinical results in brain tumor cases. An ingenious and, perhaps, hopeful technic may develop from the "neutron-capture" technic. Here, the host tumor cells containing boron, previously given intravenously, are bombarded with a stream of neutrons and each cell containing the boron "captures" a neutron and produces an intracellular "explosion", thus destroying the malignant cell from within, a miniature atom bomb, in effect.

For a more effective type of interstitial radiation, a coiled cobalt activated wire can be placed within the bed of the tumor and withdrawn after appropriate intervals of radiation exposure. These methods, however, remain experimental and their practical value has not yet been fully assessed.

Since the discovery of and the clinical availability of steroids, there has been a renewal of interest in the effectiveness of pituitary ablation in the treatment of hormone dependent neoplasms as well as in other conditions. Notably, disseminated adenocarcinoma of the breast has, in a high proportion of cases, shown a gratifying growth remission following hypophysectomy.

Cutaneous and visceral metastases may disappear following removal of the pituitary, but the most outstanding improvement occurs in metastatic bone lesions, with healing of bone, disappearance of the lesions, and relief of pain for varying periods. Since it may be difficult to effect a complete hypophysectomy, methods are being used to insure a more total ablation effect. Destruction of the gland by implantation of radioactive materials (gold or yttrium) in the sella by the transnasal route is currently in vogue, although we are still relying principally on the surgical extirpation. On theoretical grounds, it is reasonable to think that interruption of the portal system of the pituitary by hypophyseal stalk section would be tantamount to pituitary removal, but it now seems that this does not predictably produce an adequate hypophysectomy effect. Destruction of the pituitary by radiation, using the linear accelerator, has been successfully carried out and may hold greater promise than surgical ablation.

Reversal of the severe cosmetic disturbances of progressive acromegaly as well as improvement in Cushing's disease and juvenile diabetic retinopathy can be achieved by radical removal of the pituitary. Pituitary stalk section employed in one case in our clinic for Cushing's disease was not dramatically successful, although some improvement was noted.

Pain and Other Problems

In the realm of surgical control of pain, the "tried and true" operations of rhizotomy and cordotomy remain our clinical choices whenever appropriate. Newer methods of producing analgesia are desirable and the use of solutions of Pantopaque and phenol injected intrathecally at the desired segmental level seem to show a selectivity to interrupt conduction in the fine, non-medullated fibers, while preserving function in the other neural elements. On a more central basis, destruction of the receptive sensory nuclei in the thalamus by stereotactic methods or by ultrasound is still in the area of clinical research and cannot be considered appropriate for general use at present.

After 50 years of surgical experience with major trigeminal neuralgia, no single method has proven an adequate substitute for posterior root section. Intraganglionic injections of alcohol and boiling water, gangliolysis, ganglion compression, and ganglion decompression have enjoyed a limited vogue and retain a few proponents, but the long-term results of such methods have not been encouraging.

A percutaneous method of cordotomy using a small needle probe introduced into the region of the antero-lateral column of the spinal cord under X-ray control has recently been described. A small lesion is produced by local radiation destruction produced by radioactive elements in the needle tip. This method might be ideal for the patient so ill that he could not be considered a candidate for major surgery.

In certain topographical areas, notably the basal ganglia, thalamus, and brain stem, open surgical procedures have long been associated with a morbidity and mortality that precluded the continuation of such surgery. Methods of three dimensional or stereotactic surgery now being extensively explored have proven highly successful in opening a new field of endeavor for the neurological surgeon.

Destructive lesions of varying size made in the globus pallidus, putamen, thalamus, substantia nigra, and other "inaccessible" areas are now regularly utilized to alter the tremor and rigidity of Parkinson's disease, the spasticity of the cerebral palsy, and the disturbing involuntary, useless movements of dystonia and the choreo-athetoid states. Such lesions can be produced by the injection of absolute alcohol, electrocautery, leucotome cutting, freezing with liquid nitrogen, or by directed beams of ultrasound.

The armamentarium of stereotactic surgery now consists of such a bewildering array of frames, head holders, recording and stimulating devices that it leaves no doubt as to the proclivity of many clinicians to embark on a separate sub-specialty relating to surgical gadgetry. It should be emphasized that regardless of the simplicity or complexity of the method used, the most successful result possible in such disorders is a reduction or alleviation of the most disabling features of the disease and should never be construed as a basic cure.

Renewed interest in the most recalcitrant problem of infants and children has occurred with the advent of certain well tolerated tubing that can be used as shunting devices for the hydrocephalic child. Siliconed latex or plastic tubing used as a diversionary shunt from the lateral ventricle into the right auricle has now been employed successfully in hundreds of infants with progressive hydrocephalus. A satisfactory outcome is further ensured by the use of small subcutaneous pumps which can be compressed manually to maintain patency of the system.

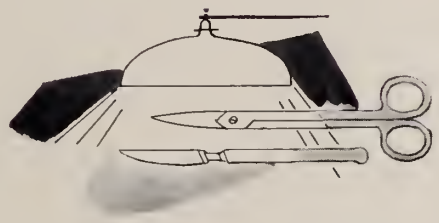
There remain many discouraging complications appended to these problems and the surgeon who undertakes such work must be dedicated to his task and prepared to carry out many revisions and corrections of the complications of this abnormal system. In our clinic, the infant with hydrocephalus and a major dysraphic state is studied under the auspices of a "Birth Defect Service," embodying the neurological surgeon, pediatrician, orthopedist, urologist, clinical psychologist, and representatives from the speech and hearing, and physical therapy departments. With such a multidisciplinary approach, we hope to formulate some basic principles in the treatment, management, and prognosis of such children, although our original plan of a five year study now appears to be insufficient, and we will probably require a second "five year plan."

Summary

Our specialty is not at a standstill, but is moving in the manner of all mature disciplines toward a gradual and laborious perfection of its technics and advancements for the betterment of the patient. In this age of highly skilled

specialization and its accompanying complex technology, it is indeed comforting to realize that no device yet invented can be even a poor substitute for that most valuable tool of our profession: *clinical judgment*. This rather mundane trait can exist without the aid of complex diagnostic aids, but when coupled with the practical awareness of, and the judicial use of laboratory adjuncts, a first-rate clinical performance will inevitably result. Nor should we lose sight of the contributions of those who preceded us since no contemporary advance is ever made without some benefit being derived from the success and failure of previous generations.

The words of Harvey Cushing are as true today as in 1926 when he said, "By slow processes we have come to broaden our horizon, but we do not for a moment forget that we are merely standing on the clustered shoulders of those here unnumbered and unnamed persons who laboriously worked out for the benefit of our generation the development and finer anatomy of the brain, who discovered the localization of its functions, untangled the pathways of its impulses, determined the clinical expression of its lesions, bequeathed to us the instruments we depend upon, laid the foundation stones of modern craniocerebral surgery and more besides."



Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Environmental Factors in Lung Cancer: An Epidemiologist's Point of View†

Christian R. Klimt, M.D.*
Baltimore, Md.

In general populations epidermoid lung cancer is most consistantly and most strongly associated with cigarette smoking, though other environmental associations not explained by differences in smoking habits have been found.

LUNG cancer has been found associated with certain industrial processes and occupations such as uranium mining, chromate, nickel and asbestos industries; with more general environmental factors like urban living, low income or socio-economic group, the birth cohort into which a person was born and the concomitantly increasing factors as air pollution, urbanization and industrialization, social stress, and with cigarette smoking, duration of smoking, amount smoked and depth of inhalation.

The fundamental fact of public health concern is the dramatic increase of death rates from lung cancer during this century in virtually all countries with adequate mortality statistics by cause. In the United States between 1930 and 1960 the age-adjusted death rates increased for males tenfold and for females threefold. Increases have been evident since 1900. Neither aging of our population nor misclassification can explain away the fact of a substantial increase in lung cancer mortality, which has been observed for no other cancer. Lung cancer, previously a rare disease, accounts for more deaths than all other respiratory diseases combined. In males at least the mortality curve over time shows not only an increase but suggests also a rise in the rate of increase.

Criteria

Among the various environmental factors of a general nature one has looked therefore for one which meets all of the following criteria:

1) Is inhaled by humans.
2) Has increased in all nations during the course of the 20th century.
3) Has males selectively more exposed than females.
4) Is found more frequently in an urban environment and in lower socio-economic population groups.
5) Is not effective in Seventh Day Adventists, who practice the faith since birth.
6) Affected Icelanders later than other nations.
7) Has been demonstrated in animals to possess cancerogenic properties.

Cigarette smoke, in contrast to cigar or pipe smoke, because of its less irritant and chemically neutral quality, meets the first condition of inhalation. Tobacco consumption statistics show compatibility with the next three criteria.

Per capita consumption of tobacco has been, and is still increasing, and all nations have participated in this trend. Males smoke more and are more frequently smokers than women, and contrary to the opinion of some researchers, urban dwellers do smoke more than inhabitants of rural areas.

A study among Seventh Day Adventists showed the disease to be virtually absent except in some recent converts, who previously smoked. Apart from tobacco, alcohol and certain foods are prohibited for Seventh Day Adventists. In Iceland the cigarette smoking habit became popular as late as 1940 and lung cancer rates went up later than in other nations. Incidentally, air pollution in Iceland's capital Reykjavik, is less than in any other modern

---

† *Presented at the Fourth General Scientific Session of the Kentucky State Medical Association Annual Meeting in Lexington held September 24-26, 1963.*

**Associate professor and director, division of Epidemiology, University of Maryland School of Medicine, Baltimore.*

city, as its heating requirements are met from natural hot springs.

Experimental work has isolated at least 16 different cancerogenic materials from tobacco smoke condensates, including the well known benz-pyrenes and at times arsenic stemming from plant sprays for disease prevention.

Air pollution through industrial combustion, gasoline fumes and automobile tire particles has been suggested as a cause of lung cancer, but none of these facts meet all the above criteria. While adjustment for smoking differences between urban and rural populations does not account or all the difference in lung cancer rates—an unaccounted-for residual of 34% excess remains—the smoking correlation has been convincingly demonstrated separately for urban and for rural dwellers.

Necropsy studies demonstrated that the increase in lung cancer is almost exclusively due to the more frequent epidermoid or Kreyberg Type I kind and not to adeno or alveolar lung cancers. The association of smoking to lung cancer is limited to epidermoid lung cancers, which in turn are nearly absent in non-smokers. Hammond and Horns prospective study found a rate of 3.4 per 100,000 men years of observation of Kreyberg Type I cancers for non-smokers and a rate of 217, or 60 times as high for heavy smokers.

At least 27 retrospective studies from nine countries, two of them restricted to women, have shown lung cancer victims to be more frequently smokers than matched controls. While the adequacy of controls in such studies is always subject to grave doubt, and the possibility of biased reporting by lung cancer patients or their relatives exists, the consistency of the results obtained under such a variety of conditions is impressive.

Prospective Studies

Three prospective studies of large population groups, Doll and Hill among English physicians, Hammond and Horn among friends of Cancer Society volunteers, and Dorn among persons with government health insurance through the Veterans Administration, have substantiated and complemented the findings of the retrospective studies. They too, suffer varying inadequacies, including the possibility of sampling bias and relevance to restricted populations only. Taken together and combined with necropsy and laboratory evidence, there remains hardly any doubt with regard to the existence of a causal relation between smoking and epidermoid lung cancer. This is borne out by strong policy statements by such organizations as the Royal Society of Physicians and the Surgeon General of the USPHS, the American Cancer Society, the American Public Health Association and others.

Argument is still possible with regard to quantitative estimates of this effect, as nobody has claimed that smoking is the exclusive cause of lung cancer, although it may yet turn out to be the exclusive cause of the rise in epidermoid lung cancer rates observed during this century or at least since 1920, when cigarette smoking became the overwhelming form of tobacco use. In various published estimates of the quantitative effect of cigarette smoke on lung cancer, between 56 and 92% have been ascribed to smoking.

Multiple Associations

While this discussion is limited to the role of environmental factors in cancers of the lung, my presentation would be incomplete without the mention of the quantitatively more important associations—in contrast to the degree of association—of smoking with coronary artery disease, chronic bronchitis and gastric ulcer, as well as with some less frequent diseases as cancer of the bladder and cancer of the buccal cavity. Incidentally, the latter is equally strong for all types of smoking; pipe, cigar or cigarette.

Such associations, be they causal or be they detrimental only to already diseased persons, or indeed, if they are incidental, due to a common as yet undefined X-factor, do not detract from the very much stronger association found for lung cancer. Multiple associations of an environmental factor with a variety of diseases are commonly found and are to be expected, for as complex a chemical as tobacco smoke.

From a public health point of view, the association of cigarette smoking with deaths from myocardial infarctions is of still greater concern than the one with lung cancer, as one deals with much larger numbers of excess deaths.

Bone Marrow Failure and Myelofibrosis †

John A. Shively, M.D.*
Lexington, Ky.

The interrelationship of bone marrow failure, myelofibrosis, and myeloid metaplasia is reviewed. Myeloid metaplasia occurring with myelofibrosis may represent the transition between reaction to injury and neoplasia as seen in the myeloproliferative group of diseases.

THE relationship of bone marrow failure and myelofibrosis is a challenging but poorly understood association and also concerns the formation of blood at extramedullary sites or myeloid metaplasia. Fibrosis develops only in some cases of failure of the bone marrow, and extramedullary hematopoiesis may be considered either a compensatory mechanism or else a response to the same stimulus provoking the fibrous connective tissue reaction in the marrow.

Hematopoiesis

As one attempts to relate these processes, it is essential to establish three concepts of hematopoiesis. First, the bone marrow is considered the largest organ in the body. Second, the concept of relative failure of this organ is important.[17, 18] Like the adrenal and the heart, it may fail completely or have relative degrees of competency. Normally the bone marrow may increase red cell production six to eight times the normal rate.[6] An individual with relative marrow insufficiency will have a normal red count as long as the number produced equals the number destroyed. If there is an increase in the rate of destruction of red cells, the patient with the incompetent marrow becomes anemic in a manner similar to the cardiac patient who is well compensated at rest but becomes dyspneic when walking upstairs. Third, when myeloid metaplasia or extramedullary hematopoiesis occurs, it occurs in organs in which hematopoiesis has appeared during fetal or early neonatal life, i.e. spleen, liver, and lymph nodes. [13, 2]

Bone Marrow Failure

In order to clarify the interrelationship of bone marrow failure, myelofibrosis, and myeloid metaplasia, a brief review of each of these processes is helpful. Bone marrow failure may be due to a number of causes. A congenital form is recognized as well as several varieties of familial aplastic anemia, one of which includes the Fanconi syndrome or amino aciduria.[16]

Bone marrow failure is also associated with displacement of the normal hematopoietic tissue by foreign material such as metastatic neoplasms, leukemic or lymphomatous tissue, granulomata due to known infectious agents, and displacement by bone as seen in osteopetrosis. Ionizing radiation also can cause marrow damage and subsequent bone marrow failure.

Damage of the marrow due to chemical agents is well known. One of the first such agents to be recognized was benzol, as well as some of the heavy metals such as arsenic and gold.[7] Damage due to chloramphenicol has been recognized, and incubation of marrow cells with high concentrations of this drug *in vitro* has resulted in inhibition of nucleic acid synthesis.[29] In uremia as well as in infections there is a depressant effect on the bone marrow with decreased hematopoiesis or relative marrow failure.[28]

Antigen-antibody reactions can cause either total or at least relative bone marrow failure as shown by Giblett[10] who studied red cell production in an infant who had hemolytic disease of the newborn due to Rh sensitization. She found that as long as there were circulating antibodies present there was inhibition or lack of erythropoiesis. Many cases of idiopathic thrombocytopenic purpura, in which there are large numbers of megakarocytes in the bone

† *Presented at the April 26, 1693 meeting of the Association of Clinical Scientists in Louisville.*

* *Associate professor of pathology at the University of Kentucky College of Medicine in Lexington, Ky.*

marrow, are associated with circulating antiplatelet antibodies and lack of thrombocyte formation.

Fibrosis of Marrow

Fibrosis of the marrow can be produced in the experimental animal in a number of ways. The methods used may illustrate possible mechanisms for the production of myelofibrosis in man. The intravenous administration of the hemolysin, saponin, will cause hemorrhage into the marrow tissue with subsequent necrosis and fibrosis of the bone marrow of rabbits.[5] This is associated with extra medullary hematopoiesis in the spleen, liver and other organs which would seem to be purely a compensatory phenomena secondary to bone marrow insufficiency.

Nettleship[21] produced in the guinea pig an antibody to rabbit bone marrow. By injecting such serum into rabbits he noted hemorrhage and necrosis in the bone marrow with subsequent fibrosis. The production of multiple small marrow infarcts in rabbits likewise results in fibrosis of the marrow.[12]

In birds as well as mice the administration of estrogens will cause the deposition of fibrous connective tissue in the bone marrow as well as bone formation in the marrow space[9]. This process can be prevented if androgens are given with the estrogens. Recently, Selye has developed the technique of injecting lead acetate intravenously into rabbits and producing myelofibrosis with subsequent ossification and bone formation in the middle of myeloid tissue.[25]

Fibrosis of human bone marrow has been found in benzene poisoning, in which there is either a normal cellular or hyperplastic marrow associated with prolonged exposure to the chemical.[15,28] This observation raises the possibility that prolonged exposure of a toxic agent or chemical in small amounts may be an important factor in development of fibrosis. However, the majority of cases of myelofibrosis in man which cannot be attributed to a specific process (i.e. metastatic malignancy, lymphoma, leukemia), exhibit clinical and pathological findings which are recognized as a clinical entity.

In these cases, the cause of the marrow fibrosis with concomitant development of marrow insufficiency is not known. The process is progressive in character and is associated with extramedullary hematopoiesis in the spleen, liver, lymph nodes and other organs.[13] There is almost always an associated splenomegaly in these patients.[23] An anemia is usually present which varies in severity. Poikilocytes which are frequently "tear-drop" or "comma" shaped are usually found in the peripheral blood.[14] There is considerable variation in the leukocyte and platelet count ranging from a marked depression to elevated levels of both leukocytes and platelets.[23] Immature white cells of the granulocytic series, along with varying numbers of nucleated red cells, are present producing a "leukoerythroblastotic" blood picture. The leukocyte alkaline phosphatase content shows no consistent pattern, low, normal and high values being found in the patients.[20] In the bone marrow there is first focal and later diffuse progressive deposition of fibrous connective tissue, often associated with a striking increase in the number of megakaryocytes but with a decrease in the remaining hematopoietic cells.[7]

Myeloid Metaplasia

The myeloid metaplasia or extramedullary hematopoiesis has been considered to be compensatory to bone marrow insufficiency, but this concept has been questioned because extramedullary hematopoiesis has been observed prior to myelofibrosis[4]. If the proliferation of the extramedullary hematopoietic tissue is due to the same stimulus as the fibrosis in the marrow, this entity may be a variant of the so-called myeloproliferative diseases along with erythremic myelosis, granulocytic leukemia, polycythemia vera, and multiple myeloma.[20] These clinical entities would represent examples or manifestations of proliferating primitive stem cells. The final product or cell type may be red blood cells, plasma cells, osteocytes, leukocytes, platelets, fibroblasts or reticulum cells.[11] Wasserman[27] believes that there is an interrelationship among polycythemia vera, myelofibrosis and myeloid metaplasia. The latter two represent the end stages of the process and a decrease in erythropoietic activity.

Bouroncle and Doan[3] in reviewing 110 cases of myelofibrosis found that 20% of these patients had "acute blastic phase" prior to death; i.e., immature white cells and an increasing number of myeloblasts in the peripheral blood while fibrosis predominated in the bone marrow. This may indicate that if patients with myelofibrosis and myeloid metaplasia were supported long enough many of

them might die in a "blast" phase, not unlike the terminal phase usually seen in erythremic myelosis and erythroleukemia.

Etiology

The cause of these proliferative changes in the bone marrow (fibrosis and increased numbers of megakaryocytes) associated with myeloid metaplasia and extra-medullary hematopoiesis has been the focus of much speculation. If these are truly reactive changes, why do they not occur in all cases of bone marrow failure?

Selye[24] has proposed that a chronic intoxication due to products liberated from necrotic tissues can cause myeloid transformation in organs other than bone marrow. He has presented evidence that this can occur in the experimental animal. This concept is in keeping with the proposal by Peace[22] that myelofibrosis with extramedullary myelopoiesis and leukoerythroblastosis in man is a general mesenchymal reaction to necrosis of immature cells of the hematopoietic system.

An occult viral infection could also be the stimulating agent and Upton and Furth[26] have found such an agent in mice. It produced chronic anemia, leukopenia, erythropoietic splenomegaly and myelosclerosis. Dameshek and co-workers[1] have reported three cases of tuberculosis and myelofibrosis with myeloid metaplasia. They raise the question of the possible role that the tubercle bacillus plays in the cause of myelo-proliferative diseases instead of just being the etiology of a secondary infection.

Comment

Metcalf[16] has proposed that prolonged antigenic stimulation may result in proliferative changes in the reticuloendothelial tissues which, either because of an abnormal stimulus or abnormal response by the host, occasionally result in neoplasia instead of hyperplasia. While this is an attractive hypothesis, confirmatory evidence is needed. At the present time, the statement of Leonard, Israels and Wilkinson[13] that myelofibrosis is a morphologic entity without etiologic unity would appear to be true.

A continuing search for the relationship between bone marrow failure, myelofibrosis and myeloid metaplasia is worthwhile. The cause of these processes may be the link between reactive changes due to injury or infection (fibrosis and proliferation of megakaryocytes) and neoplasia or unrestricted proliferation as seen in the myeloproliferative group of diseases.

Summary

The relationship of bone marrow failure, myelofibrosis and myeloid metaplasia have been reviewed along with some of the methods used for the experimental production of these processes. The possible cause of myelofibrosis with myeloid metaplasia in the human is discussed as well as its relationship to the myeloproliferative group of diseases.

References

1. Andre, J., Schwartz, R., and Dameshek, W.: Tuberculosis and Myelosclerosis with Myeloid Metaplasia, J.A.M.A., 178, 1169-1174, 1961.
2. Block, M. and Jacobson, L. O.: Myeloid Metaplasia, J.A.M.A., 143, 1390-1396, 1950.
3. Bouroncle, B. A. and Doan, C.A.: Myelofibrosis-Clinical, Hematologic and Pathologic Study of 110 Patients, Am. J. M. Sc., 243, 697-715, 1962.
4. Bowdler, A. J. and Prankerd, T. A. J.: Primary Myeloid Metaplasia, Brit. J., 1, 1352-1358, 1961.
5. Bunting, C. H.: Experimental Anemias in the Rabbit, J. Exper. Med., 8, 625-646, 1906.
6. Crosby, W. H. and Akeroyd, J. H.: The Limit of Hemoglobin Synthesis in Hereditary Hemolytic Anemia, Am. J. Med., 13, 273-283, 1952.
7. Erf, L. A. and Hebrut, P. A.: Primary and Secondary Myelofibrosis (A Clinical and Pathological Study of Thirteen Cases of Fibrosis of the Bone Marrow), Ann. Int. Med., 21, 863-889, 1944.
8. Firket, J. and Campos, E. S.: Generalized Megalokaryocytic Reaction to Saponin Poisoning, Bull. of the John Hopkins Hosp., 33, 271-283, 1922.
9. Gardner, W. U. and Pfeiffer, C. A.: Influence of Estrogens and Androgens on the Skeletal System, Physiol. Rev., 23, 139-165, 1943.
10. Giblett, E. R., Varela, J. E., and Finch, C. A.: Damage of the Bone Marrow Due to Rh Antibody, Pediatrics, 17, 37-44, 1956.
11. Hutt, M. S. R., Pinniger, J. L., and Wetherley-Mein, G.: The Myeloproliferative Disorders with Special Reference to Myelofibrosis, Blood, 8, 295-314, 1953.
12. Kistler, G. H.: Sequences of Experimental Infarction of the Femur in Rabbits, Arch. Surg., 29, 589-611, 1934.
13. Leonard, B. J., Israels, M. C. G., and Wilkinson, J. K.: Myelosclerosis, A Clinicopathological Study, Quart. J. Med., 26, 131-147, 1957.
14. Linman, J. W. and Bethell, F. H.: Agnogenic Myeloid Metaplasia, Am. J. Med., 22, 107-122, 1957.
15. Mallory, T. B., Gall, E. A., and Brickley, W. J.: Chronic Exposure to Benzene (Benzol) III. The Pathologic Results, J. Indust. Hyg. and Toxicol., 21, 355-377, 1939.
16. Metcalf, D.: The Aetiology and Pathogenesis of Leukemia, Australasian Ann. Med., 11, 211-218, 1962.
17. Miale, J. B.: Laboratory Medicine—Hematology, Second Edition, St. Louis, C. V. Mosby Co., 1962.
18. Moore, C. V.: Editorial—The Concept of Relative Bone Marrow Failure, Am. J. Med., 23, 1-4, 1957.
19. Movitt, E. R., Mangum, J. F., Jung, E. D., and Porter, W. R.: True or Absolute Bone Marrow Failure, Am. J. M. Sc., 244, 306-315, 1962.
20. Nakai, G. S., Craddock, C. G., and Feguerva, W. G.: Agnogenic Myeloid Metaplasia, Ann. Int. Med., 57, 419-440, 1962.
21. Nettleship, A.: Bone Marrow Changes Produced by Specific Antibodies, Am. J. Path., 18, 689-698, 1942.
22. Peace, R. J.: Myelonecrosis, Extramedullary Myelopoiesis and Leuko-Erythroblastosis, A Mesenchymal Reaction to Injury, Am. J. Path., 29, 1029-1050, 1953.
23. Pitcock, J. A., Reinhard, E. H., Justus, B. W. and Mendelsohn, R. S.: A Clinical and Pathological Study of Seventy Cases of Myelofibrosis, Ann. Int. Med., 57, 73-84, 1962.
24. Selye, H., and Stone, H.: Hormonally Induced Transformation of Adrenal into Myeloid Tissue, Am. J. Path., 26, 211-234, 1950.
25. Selye, H., Gabbiani, G., and Tuchweber, B.: An Experimental Model of Osteomyelosclerosis, Acta haemat., 29, 51-62, 1963.
26. Upton, A. C. and Furth, J.: A Transmissible Disease of Mice Characterized by Anemia, Leukopenia, Splenomegaly and Myelosclerosis, Acta haemat., 13, 65-76, 1955.
27. Wasserman, L. R.: Polycythemia Vera—Its Course and Treatment: Relation to Myeloid Metaplasia and Leukemia, Bull, New York Acad. Med., 30, 343-375, 1954.
28. Wyatt, J. P. and Sommers, S. C.: Chronic Marrow Failure, Myelosclerosis, and Extramedullary Hematopoiesis, Blood, 5, 329-347, 1950.

The Importance of Added Humidity With Mechanical Respirators

LESTER R. BRYANT, M.D.*
Lexington, Ky.

Serious complications in the use of respirators may be avoided by attention to the techniques of humidifying the inflow air.

WITH normal resting ventilation, a normal airway is able to provide adequate moisture to raise the inspired air to 100 percent relative humidity at the alveolar level. This function is performed principally by the nasal passages which have a large surface area compared with their lumen. The lower respiratory passages have a small surface area compared with their lumen and are designed to receive saturated air only.

The natural protective mechanisms of the lower airways operate better with a moist respiratory surface than with a dry one. When it is necessary to bypass the upper respiratory tract, as with a tracheostomy tube, the lower respiratory surfaces may become dry. As a result, ciliary action is depressed and airway secretions become inspissated, with obstruction of the finer airways. Infection, frequently with antibiotic resistant bacteria, and atelectasis then follow.

The value of mechanical respirators in the management of ventilatory insufficiency from various causes is well established. In circumstances requiring the use of a mechanical ventilator for more than a few hours, tracheostomy is usually performed. The sequence of events mentioned above, may then be exaggerated as a result of the hyperventilation and dessicated medical gases used with the respirator. Secretions tend to dry around the end of the tracheostomy tube, and this is all the more important if a "patient-triggered" machine is being used, since it will lead to a rapid build up of pressure between the machine and the obstruction, and the patient will be decreasingly ventilated. Airway obstruction by dried bronchial secretions is a constant threat to a patient depending for life on a respirator and several authors[2, 3] have reported fatalities from inadequate humidification with mechanical ventilators.

There has been continued improvement in the humidifying systems supplied with commercial respirators and several types are available which warm as well as humidify the inflow temperature becomes unsaturated as it is warm-air. Such units take into account the fact that air which is saturated with water vapor at room ed in the tracheobronchial tree. A majority of respirators in present use, however, require some form of added moisture for safe and satisfactory operation. The technique to be described below was developed to serve this purpose, and has given excellent results in patients being maintained on a respirator as well as in patients with a tracheostomy alone.

Technique For Humidification

In cases of respiratory insufficiency in which the use of a mechanical respirator is anticipated the tracheostomy is performed and a Mörch swivel tracheostomy cannula is inserted. This is a modification of the standard Jackson tube, and air exchange between the respirator and patient takes place through a side-arm of the cannula. The proximal end of the cannula is fitted with a removable screw cap which was originally designed to allow easy passage of a catheter into the tube for aspiration of secretions.

* *Assistant professor of surgery at the University of Kentucky College of Medicine, Lexington, Ky.*



Figure 1. An intravenous needle in the tracheostomy cannula allows steady delivery of the solution into the trachea.

After the patient is connected with the respirator and ventilation has begun, the screw cap is replaced with a thin rubber stopper from a medication bottle (the rubber stopper from a 250 mg. vial of Dilantin® sodium is usually used, but any with an outside diameter of 1 cm. are satisfactory).

The solution to be used for humidification is then prepared by adding one part of Alevaire® to two parts normal sterile saline. In practice, this is done by discarding all but 60 cc. of a 500 cc. bottle of 0.9 percent intravenous saline and adding 30 cc. of Alevaire to the bottle. Intravenous tubing is then used to connect the bottle to a 23 or 25 gauge needle, which is passed through the rubber stopper into the tracheostomy cannula (Fig.1).

This solution is then allowed to drip into the cannula at a rate of 30 cc. per hour. The stroke volume of the respirator serves to distribute the droplets of solution throughout the tracheobronchial tree.

Although the mixture of Alevaire and saline can be made up in quantities sufficient to last for 24 hours, no more than 90 cc. is placed in the reservoir bottle at a time. This is done to prevent a catastrophe in the event of accidental release of the regulating clamp on the connecting tube. For the purpose of aspirating secretions, the rubber stopper with the needle still in place is simply removed from the cannula and a suction catheter passed down into the trachea.

This technique has been used in more than 30 consecutive cases during the past two years, for periods ranging from one to 25 days. No difficulties have been encountered with the aspiration of secretions from these patients, and none have developed airway obstruction from the formation of tracheal or bronchial casts. Postmortem examination of the lungs in three of the five patients who died showed a moist and glistening tracheo-bronchial mucosa with no evidence of bronchiolar plugging.

The simplicity and dependability of this method for providing adequate humidification serves to recommend its general use with mechanical respirators.

Summary

Humidification of the inflow air is an important problem with the use of mechanical ventilators. A simple technique has been developed which offsets the drying effect of hyperventilation and by-pass of the upper respiratory tract.



Figure 2. Removal of the rubber stopper and needle as a unit permits direct aspiration of tracheal secretions.

References

1. Bjork, V.O. and Engstrom, C.G.: The Treatment of Ventilatory Insufficiency after Pulmonary Resection with Tracheostomy and Prolonged Artificial Ventilation, J. Thoracic Surg. 30:356, 1955.
2. Hood, R.N. and Rush, C.E.: Lethal Hazards of the Morch Respirator, J. Thoracic Surg. 43:338, 1962.
3. Spencer, F.C., Benson, D.W., Liu, W.C. and Bahnson, H.T.: Use of a Mechanical Respirator in the Management of Respiratory Insufficiency Following Trauma or Operation for Cardiac or Pulmonary Disease, J. Thoracic Surg. 38:758, 1959.

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville Veterans Hospital

Peptic Esophagitis

Herbert T. Ransdell, Jr., M.D.*

PEPTIC ulceration with subsequent stenosis of the esophagus is an entity that has frequently been overlooked in the past as a frequent cause of "indigestion." In view of the recent advances in the diagnosis and management of this disease, it might be profitable to review these advances.

Case Report

A.M., a 66-year-old retired farmer was admitted to the Louisville Veterans' Hospital January 10, 1961, with complaints of recurrent cramping abdominal pain. Seven weeks before admission he had a sudden onset of lower abdominal cramping with nausea and occasional vomiting, from which he felt he could and did obtain relief with a bowel movement or an enema. There was no relation of these attacks to food intake.

One week after onset of these symptoms he was admitted to a local hospital. Diagnoses of "ulcers" and "diabetes" were made. He was placed on 30 units NPH insulin daily, was discharged after five weeks' hospitalization, and was told that "his ulcers were all right." Abdominal cramping persisted intermittently throughout his hospitalization, but did improve. He had been able to control the attacks of pain by enemas.

The improvement continued for a few days following his hospital discharge, but abdominal cramps again became severe two days prior to his admission to the Veterans' Hospital.

Although past history revealed that he had been under a doctor's care for an "ulcer," diagnosed by x-ray, during the summer of 1960, it was otherwise not remarkable.

Physical examination revealed an obese, alert, cooperative white male complaining of severe lower abdominal cramping pain; blood pressure 120/80; pulse 104; respiration 32; and temperature 98°.

There was diffuse abdominal tenderness more marked in the periumbilical area. No masses were palpated and peristalsis was normal. Rectal examination was normal, as was the remainder of the physical.

*From the department of Surgery, University of Louisville School of Medicine, Louisville; and the Louisville Veterans' Hospital, Louisville, Kentucky.

Laboratory

Admission blood count, sedimentation rate, and serum amylase were within normal limits. Urine analysis showed 10 to 15 W.B.C.'s and one plus albumin; but was otherwise normal. The day following admission, total blood proteins were 6.8 g., with 2.7 g. of albumin. BUN was 20 mg.%. Repeat blood counts on two occasions his first two days were normal. On January 16, 1961, P-proteus was cultured from his urine. On January 18, 1961, total serum bilirubin was 0.45 mgm. % and cephalin flocculation was negative; alkaline phosphatase 7.3, Bodansky units, and fasting blood sugar 161 mgm. %.

X-Rays

Admission chest x-ray and flat film of the abdomen were normal, as were subsequent small bowel series, barium enema, gall bladder series; and intravenous pyelogram. Gastrointestinal series showed a small "sliding hiatal hernia."

Hospital Course

He was placed on a bland diet and mild sedation shortly following admission. Furadantin, 100 mgm. Q.1.D., controlled the urinary infection. Relief of the abdominal cramps was obtained with Pavatrine-phenobarbital and Dramamine, and his diabetes controlled with a 1,000-calorie, bland, low residue diet. He was discharged to his private physician on February 11, 1961, with a diagnosis of diabetes mellitus mild, and bacteriuria.

He was readmitted to the Lousiville Veteran's Hospital June 12, 1961, with complaints of persistent nausea and vomiting. He said he had done well with the medications prescribed at the previous hospital discharge until about one month before his present admission, when he had an onset of recurrent vomiting of increasing frequency and severity, and without abdominal pain. Any food or water swallowed did not seem to reach his stomach, but was promptly regurgitated shortly after swallowed. He had lost 20 pounds in weight, and was rather weak. There had been no hematemesis or melena.

Physical revealed a well-developed, fairly well-nourished, chronically ill, white male, blood pressure 130/80, temperature 99°, pulse 100, respiration 24, who was otherwise normal.

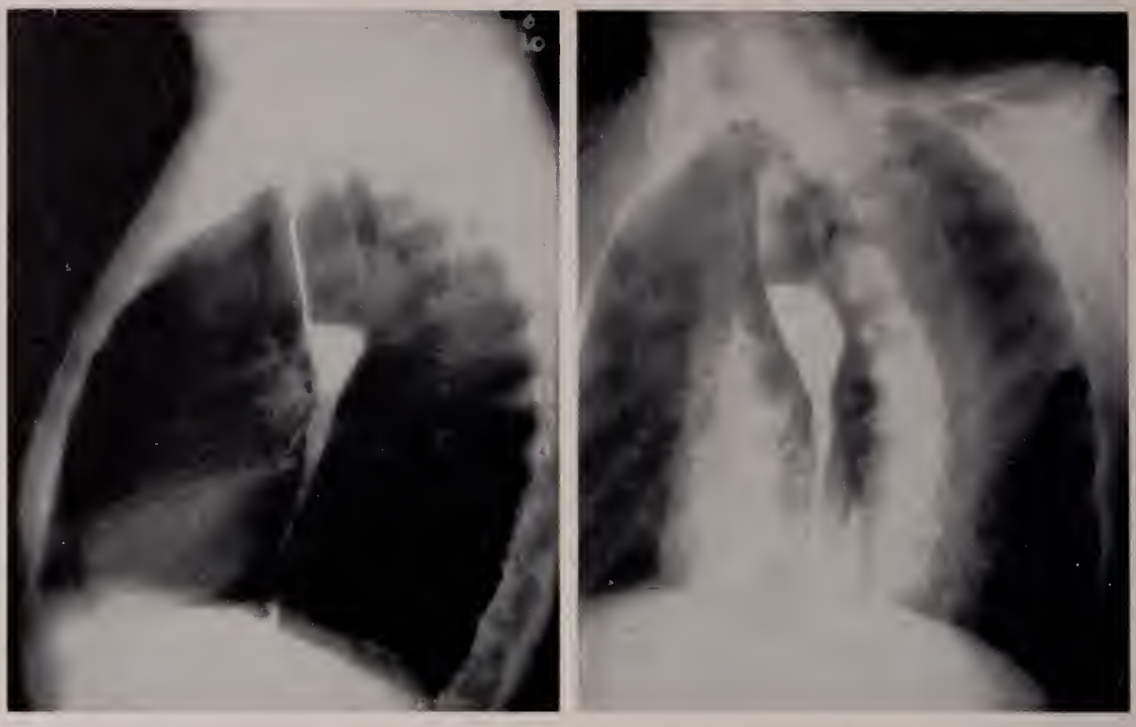


Figure 1. (a) Lateral and (b) oblique chest x-rays with barium swallow showing stricture lower one-half of esophagus, June 15, 1960.

Laboratory Studies

Admission urine was normal, hemoglobin 16.4 g. and hematocrit 47.9%; white blood count was normal; fasting blood sugar 112; BUN, bilirubin, thymol turbidity, serum proteins, alkaline phosphatase, amylase, and the blood electrolytes were all normal. Two of three stools were positive for occult blood.

On June 21, 1961, gastric analysis revealed a total acidity of 129°, with free acid of 106°; and after histamine, a total acidity of 87° with 110° of free acid; overnight 12-hour total gastric secretions were 1300 cc. with a total acidity of 135° and a free acid of 117°.

A barium swallow and upper gastrointestinal series obtained on June 15, 1961, showed narrowing down to 0.4 to 0.7 cm. of the distal 15 cm. of the esophagus, with moderate dilatation of the esophagus above the stricture, and moderate delay of passage of the barium through the narrowed area. The stomach and duodenum were normal in all aspects and no diaphragmatic hernia was seen.

The comparable films of January, 1961, were again reviewed, but no evidence of stricture was detectable. Esophagoscopy was done June 22, 1961, and showed marked injection and friability of the esophageal mucosa, and fibrous stricture permitting passage of only a #20 esophageal bougie in the lower esophagus beginning 33 cm. from the level of the upper incisors.

Course in Hospital

When admitted, he was able to swallow only small amounts of fluid and required feeding by nasogastric tube.

He was placed on an intensive antiulcer routine, including Sippy diet and Aludrox, June 21, 1961. There was some improvement during the next two to three weeks in that he was able to swallow liquids with only slight difficulty, but was still unable to swallow solid foods.

A repeat of the esophagram on July 12, 1961, showed persistence of the stricture, with no change as compared to the films of June 15, 1961. It was the opinion of the Chest Board that the distal half of the esophagus was irreparably damaged and would have to be removed. In view of the high gastric acidity, an accompanying vagotomy and pyloroplasty was believed desirable.

Using a two-team surgical approach, on July 26, 1961, exploration of the esophagus through the chest showed moderate thickening and fibrosis of the lower two-thirds of the esophagus with the lumen of the lower one-half practically obliterated. There was moderate periesophagitis and a sliding 7 x 4 cm. hiatal hernia. The stomach and other abdominal viscera were normal.

The lower one-half of the esophagus was removed along with the adjacent vagus nerves; the stomach was mobilized and pulled into the chest and anastomosed to the remaining upper esophagus, and a Heineke-Mikulicz pyloroplasty done.

His postoperative course was uneventful. The nasogastric tube was removed one week after operation and a full liquid diet started. Within two weeks he was taking a soft diet and within three weeks was taking a regular diet without difficulty. A gastrointestinal series at this time showed good function of the remaining esophagus and passage of barium through the esophageal junction with no delay. A Dragstedt test showed no free acid in the stomach.

He was discharged August 26, 1961, in good general condition, with no complaints. He was last seen December 17, 1962, and was doing well and was taking a regular diet with no difficulty. There had been no further difficulty with "indigestion" or abdominal cramp.

Discussion

Esophagitis has been established experimentally and clinically as an entity related to acid pepsin digestion of the esophageal mucosa, usually associated with an incompetent cardioesophageal junction which permits regurgitation of the gastric contents into the lower esophagus.

Incompetent cardioesophageal junctions and esophagitis are often associated with diaphragmatic hernias, gastric outflow obstruction, persistent nausea and vomiting, indwelling nasogastric tubes and are occasionally found as the only apparent entity. Esophagitis is most commonly found in patients manifesting an ulcer diathesis in the forty-to-seventy age group, and shows a higher ratio of female to males than is usual in cases of peptic ulcer of the stomach and duodenum.

Symptomatology is extremely variable. The typical patient presents with complaints, for varying periods of time, of substernal pain, often described as "heart burn"; or dyspepsia, usually aggravated by food intake and alcoholic sprees, as well as by lying down. Occult gastrointestinal bleeding is occasionally seen, and rarely, massive gastrointestinal hemorrhage. Dysphagia may be present and may be slowly progressive to almost complete obstruction, particularly in the older age group.

Physical examination is of little help in the diagnosis as the majority have no physical findings referable to the esophagitis.

X-ray studies often demonstrate the sliding diaphragmatic hernia found associated with the esophagitis in about 80 percent of the patients. Actual reflux of the barium from the stomach into the lower esophagus through an incompetent cardioesophageal junction may be seen in the majority, particularly if the radiologist is searching for regurgitation and performs the necessary maneuvers to aggravate the incompetence. In further advanced cases, varying degrees of stricture of the lower esophagus are seen.

All patients suspected of having esophagitis should be esophagoscoped. Reddening and edema of the esophageal mucosa, often with superficial ulceration for several centimeters proximal to the cardioesophageal junction, is highly suggestive of esophagitis. Regurgitation of the gastric contents into the lower esophagus is often seen, and displacement and abnormal mobility of the cardioesophageal junction seen with accompanying sliding hiatal hernia may be demonstrated. Biopsy of the abnormal mucosa usually confirms the diagnosis and eliminates the diagnosis of more serious pathology.

Occasionally patients will be seen with complaints consistent with esophagitis in which x-ray studies, esophagoscopy, etc., are reported as normal. A swallow of highly diluted hydrochloric acid may reproduce the patients' symptomatology in these patients, whereas it will have no effect on the normal patient. Determination of the pH and pressure wave characteristics of the upper stomach and lower esophagus may be required to demonstrate the regurgitation of the gastric contents into the lower esophagus. These determinations, however, require highly specialized and expensive equipment, but are often helpful in confirming the suspected diagnosis.

Treatment of peptic esophagitis is both medical and surgical.

In general, medical treatment is used as definitive therapy in those patients with acute esophagitis produced by prolonged vomiting, or prolonged nasogastric tube usage; in a few individuals with mild symptoms and esophagitis not associated with hiatal hernia; and esophagitis in those patients with hiatal hernia in whom elective surgery is contraindicated or refused.

Proper medical therapy is that used for peptic ulcer of the duodenum and consists of a bland ulcer diet, antacids, elevation of the head of the bed, elimination of alcoholic intake, and, if stenosis exists, dilatation of the esophagus with esophageal dilators over a previously swallowed string.

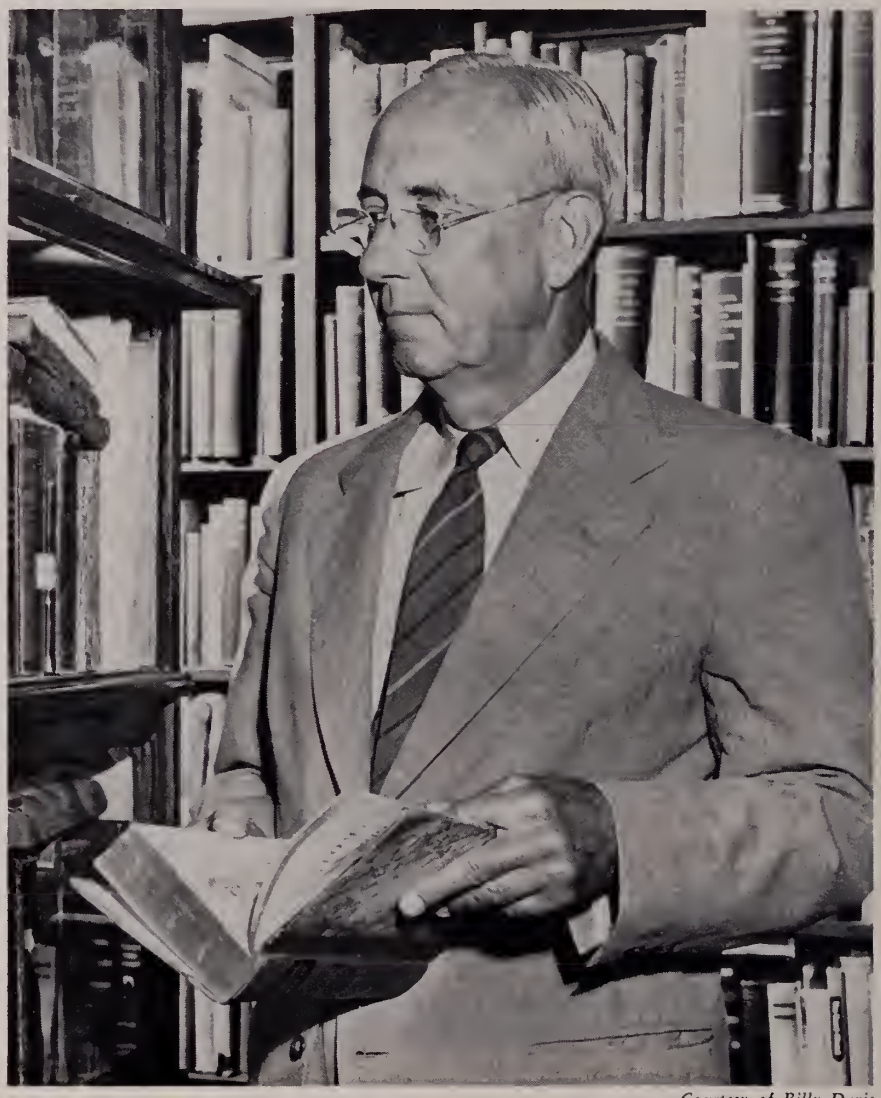
Esophagitis with sliding diaphragmatic hiatal hernia responds well to repair of the hernia and correction of the incompetency of the cardioesophageal junction. Surgery should therefore be insisted on when esophagitis is seen with diaphragmatic hernia.

Severe reflux esophagitis is rather refractory to medical or nonsurgical treatment. It tends to progress relentlessly towards stenosis and stricture with dysphagia. When peptic esophagitis become severe enough to result in intractable pain, bleeding, stenosis, or perforation, surgical therapy should be considered.

When one reviews the literature as to what constitutes proper surgical treatment for these severe complications of esophagitis, he becomes rather confused at the variety of procedures described. Part of the confusion may lie in the fact that everyone may not be talking about the same thing when they refer to esophagitis. Some have believed that esophagitis is not a single disease entity, but a group of conditions of related origin. Conditions so often accompanying esophagitis, such as hiatal hernia, gastric or duodenal ulcer, or destruction of the cardiac sphincter mechanism by previous surgery, may further confuse the issue. There is, however, no disagreement that the damaging effects of acid-peptic juice on the vulnerable esophageal mucosa must be curtailed if esophagitis is to be cured, but how to weigh the significance of the various contributing factors for adequate therapy poses many problems and leads to the variations in opinion existing today.

In our opinion, restoration of a competent cardioesophageal mechanism is the most important objective of surgery to correct esophagitis. This should ideally be done before the serious complications of stenosis, etc., occur, as it can be usually accomplished without difficulty in the absence of these complications. Reduction of the gastric acidity should be obtained if elevated. This can usually be accomplished by vagotomy in combination with an emptying procedure such as pyloroplasty, but may require

(Continued on Page 246)



Courtesy of Billy Davis

EMMET FIELD HORINE

Emmet Field Horine

1885—1964

Emmet Field Horine, M.D., historian of Kentucky State Medical Association since 1935, died at St. Anthony's Hospital, Louisville on February 1, following a myocardial infarction.

Until his retirement in 1946, he had practiced cardiology in Louisville for 22 years. Since retiring to his tree farm estate in Bullitt County, he had devoted himself to farming, printing, and writing.

Doctor Horine was born 3 August 1885 in Brooks, Kentucky, the son of Doctor George and Elizabeth (Barrell) Horine. In 1891 the family moved to Americus, Georgia, and it was here that he received his grade and high school education and developed his first interest in books, libraries, and printing. At Emory College, Atlanta, Georgia, he received his pre-medical education (1902-03). In 1903 his father died and the family returned to Kentucky. He attended the Kentucky School of Medicine, Louisville, and received his M.D. in 1907. He served an internship and residency at St. Anthony's Hospital, Louisville, 1907-09.

Doctor Horine entered the general practice of medicine in Louisville and soon thereafter began to teach in the University of Louisville. This association he maintained until his retirement at which time he was Professor of Medicine and Professor of Medical History.

In 1914 he married the former Helen Ruthenburg, and they had three daughters and a son.

Prior to his service in WW I he was one of an early group of Medical Anesthetists in this community. Upon his return to practice in 1919 he devoted his attentions to diseases of the heart. During 1922-23 he studied cardiology in London and Vienna.

Doctor Horine was a Diplomate of the American Board of Internal Medicine, a life member of the American College of Physicians, and a member of numerous medical societies and historical associations. He was also past president of Jefferson County Medical Society (1930), Louisville Medico-Chirurgical Society, and the Ohio Valley Medical Association.

During his lifetime he gathered approximately 20,000 volumes relating to the history of medicine, American and Kentucky history, cardiology, anesthesia, agriculture, printing, and bibliography. Recently he had distributed several special collections to the libraries of University of Louisville, University of Kentucky, and Transylvania University.

Doctor Horine was the author of over 150 scientific and historical papers, biographical sketches, and book reviews. He had published several books, one from his own press. In 1961 the University of Pennsylvania Press published his definitive biography *Daniel Drake (1785-1852), Pioneer Physician of the Mid-West*. His scholarly attainments in medical historiography had been widely recognized and respected.

Doctor and Mrs. Horine in December of 1961 gave their tree farm and game refuge "High Acres" to the Old Kentucky Home Council of the Boy Scouts of America.

Doctor Horine led a full life. He greatly enriched our profession and by exercising his talents touched the lives of many of his fellow citizens. He will be sorely missed.

SPECIAL ARTICLES

A Clinic For the Diagnosis and Treatment of Temporo-Mandibular Joint Disturbances

STEPHEN F. DACHI, D.M.D.*
Lexington, Ky.

DURING the past eighteen months, a clinic for the management of patients with pain and dysfunction of the temporo-mandibular joint, has been established at the University of Kentucky Medical Center.

The etiology of these disturbances is complex. They occur most frequently in women between the ages of 25 and 60. Studies carried out over the past few years indicate that the majority of patients do not suffer from intra-articular diseases such as arthritis. Rather, they have a myo-fascial pain dysfunction syndrome involving the muscles of mastication and arising from a combination of emotional problems, occlusal irregularities and tensional habits involving the occlusion (clenching and night grinding).

Diagnosis is based upon a comprehensive evaluation of the patient. A complete history of the patient's complaints as well as his past medical and dental history is obtained. The temporo-mandibular joints are examined for tenderness and mobility of the condyles (which is frequently limited) and the muscles of mastication are palpated for painful areas.

A complete dental examination is carried out, including an occlusal analysis and survey of the functional movements of the mandible. Radiographs of the temporo-mandibular joint area are also obtained. In most instances these films reveal no pathology, but are useful in ruling out the occasional case of intra-articular disease. Consultations from various departments in the University Hospital and the College of Dentistry are available and are frequently obtained.

The most frequent findings are a dull, aching pain in the pre-auricular area, and limitation of mandibular movements. Clicking of the joints frequntly precedes the onset of other symptoms. Often the patient is in moderate distress and exhibits considerable anxiety.

The management of these problems emphasizs the "team approach". The objectives of therapy are directed toward the relief of acute symptoms, as well as the elimination or improvement of the underlying causative factors. Therapeutic exercises accompanied by the application of either heat or cold are usually effective in relieving the painful muscle spasm. Analgesics, tranquilizers or muscle relaxants may also be employed. Appliances such as a nite-guard to decrease the intensity of bruxism as well as the adjustment of occlusal disharmonies are frequently indicated. Various types of medical, surgical or psychiatric supportive measures are also employed when indicated.

Any physician may refer patients to this clinic for consultation, diagnosis or treatment by contacting the department of Oral Diagnosis and Oral Medicine at the University of Kentucky College of Dentistry

*Associate professor and chairman, department of Oral Diagnosis and Oral Medicine at the University of Kentucky Medical Center, and chief of Dental Services for the University Hospital.

EDITORIALS

A Brighter Outlook for Mental Health

IN the last twenty years, there has been increasing interest in psychiatry and mental health. We have seen evidence of this in Kentucky in the efforts of state government to improve the lot of patients in state mental hospitals, the increasing number of psychiatrists entering private practice, the enlarging of psychiatric faculties in our medical schools, and the number of laymen who have pushed for improvements in mental health.

Nationally, this has culminated in a vast survey of needs which was performed by the Joint Commission on Mental Illness and Health, under the auspices of the Congress of the United States. This in turn has led to further legislation in the area of community mental health.

The medical profession has taken a leading role in this movement, which resulted a year ago in the first National Congress on Mental Health, sponsored by the American Medical Association in Chicago.

The KSMA Committee on Mental Health has felt that as a follow-up, information should be provided to practicing physicians and other interested people through sponsorship of a State Congress on Mental Health. Vast potential changes are in the offing. All Kentucky physicians have a great responsibility in helping to plan these changes in our state and elsewhere.

FRANK M. GAINES, M.D.

The Practitioner and the Full-Time Faculty Member

IN RECENT years there has been a growing concern about the professional relationships between the physicians in private practice and the physicians who are the full-time faculty members of the medical schools.

These two groups have, in some instances, found themselves poles apart with seemingly little in common in the way of goals and interests. It is as if they were in two different professional orbits with a poor communication system between the two.

This relationship between the two groups has been the subject of discussion for county, state and national groups. The discussions have sometimes taken the form of formal committee meetings, but more often informal and impromptu gatherings will debate the matter.

David M. Cox, M.D., during his term as president of the KSMA, indicated a special interest in developing a better and more effective relationship between the full-time faculty members of the medical schools and the practicing physicians of Kentucky. George P. Archer, M.D., as Doctor Cox's successor, expressed a similar interest and concern.

The Council on Medical Education and Hospitals of the KSMA was asked to study the relationship between the two segments of the profession and to make any recommendations that seemed appropriate.

In Kentucky, the professional relationships between the two groups of physicians have for the most part been excellent. This has not been true in all areas of the country. There remains the potential of misunderstandings and a consequent lack of unity within the profession.

It is obvious that each group plays an essential role in modern medicine. Society at large and the medical profession need both groups. Membership in either group brings its rewards, recognition, and satisfactions. There can be mutual respect between the two groups; neither needs to be second-class. Professional excellence may be pursued by members of either group.

Not long ago the program of the medical school was carried on largely by the private physicians in the community. The phenomenal growth in the fund of medical knowledge and the increasing complexity of the total health effort have been factors in the development of the full-time faculty system as they have been in the development of the many specialties in medicine.

The time and energies of the full-time faculty physician will be directed to teaching, research, administration and patient care. It is his responsibility to select and train the physician of the future. Much of the new knowledge in medicine is the result of the research efforts of full-time faculty members. In general, patient care by full-time faculty is indirect through members of a house staff, and large numbers of patients are not taken care of directly.

In contrast, the time and energies of the private practitioner are to a large extent spent on direct patient care. In our American society the bulk of patient care is provided by the private practitioner. Again it is apparent that both groups are needed in the total medical effort and that neither needs to feel threatened in a prestigious, economic, or in any way, by the other.

Although the relationship in Kentucky has been good, it is the determination of the Council of Medical Education and Hospitals of KSMA, to work toward improved communication, understanding, and cooperation between the private practitioner and the full-time faculty of the medical schools.

The people of Kentucky will be greatly benefited by a coordinated and unified effort by the medical profession of the state.

WALTER S. COE, M.D.

Be Sure to Attend

the

14th Annual KSMA Interim Meeting

at

Jenny Wiley State Park

Prestonsburg, Ky.

April 23



Young Woman
Reading a Letter

JOHANNES VERMEER
1632-1675

In Pregnancy...

METAMUCIL® Acts Gently, Safely, Effectively

brand of psyllium hydrophilic mucilloid

The highly refined mucilloid of Metamucil corrects constipation in pregnant patients simply by augmenting the natural stimulus to peristalsis.

The bland, smooth bulk provided by Metamucil softens hard fecal masses, stimulates natural reflex activity of the intestinal musculature without irritant or systemic effects and tends to restore the normal rhythms of elimination.

Average Adult Dosage: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid. Metamucil powder contains equal amounts of refined, purified psyllium and dextrose furnishing 14 calories and is available in containers of 4, 8 and 16 ounces.

Instant Mix Metamucil is supplied as individual single-dose packets, each incorporating 0.25 Gm. of sodium, in cartons of 16 and 30.

G. D. SEARLE & CO.
CHICAGO, ILLINOIS, 60680
Research in the Service of Medicine

ORGANIZATION SECTION

Five Top Authorities Will Bring Medicare into Spotlight As Featured Topic at 1964 KSMA Interim Meeting April 23

A brief but comprehensive course on urgent legislative and socio-economic problems currently facing the medical profession will be offered to KSMA members attending the 14th Annual KSMA Interim Meeting at Jenny Wiley State Park, Prestonsburg, on April 23.

Five expert speakers will address the Kentucky physicians on topics ranging in content from personal happiness to Federal intervention in health care. The program on the opposite page, released by George P. Archer, M.D., KSMA president, lists in detail the well-known lecturers on the program, and their topics.

Doctor Archer, in giving the details of the complete program, emphasized the importance of the Interim Meeting in furthering the aims of the Association, and urged all KSMA members to be present.

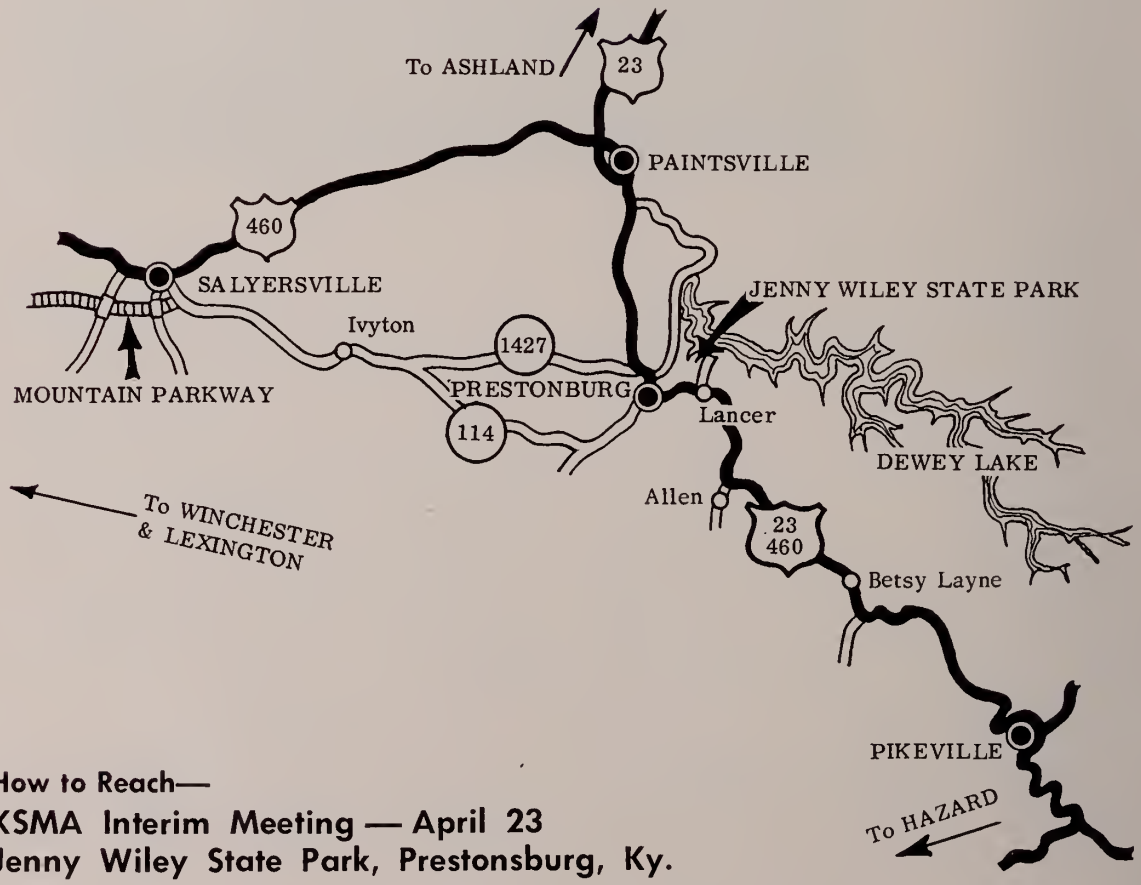
Doctor Archer will preside at the morning and luncheon sessions, and Delmas M. Clardy, Hopkinsville, KSMA president-elect, at the afternoon meeting The invocation opening the meeting will be made by Reverend W. D. Jaggers, pastor of the Irene Cole Memorial Baptist Church at Prestonsburg.

Delivering a brief address of welcome will be James Douglas Adams, M.D., president of the Floyd County Medical Society. Henry B. Asman, M.D., KSMA secretary, will make the announcements.

"The Truth About King-Anderson" will be the topic of Ernest B. Howard, M.D., assistant executive vice-president of the American Medical Association, one of the five distinguished guest speakers who will address the Interim Meeting, it was recently announced.

Doctor Howard, (see picture opposite) who has visited the state on two previous speaking engagements for KSMA, has been an executive officer of the AMA since 1948. A 1936 graduate of Boston University Medical School, he holds a Master of Public Health Degree from Harvard University.

(Continued on Page 224)



How to Reach—
KSMA Interim Meeting — April 23
Jenny Wiley State Park, Prestonsburg, Ky.

Program

KSMA 1964 Interim Meeting

Jenny Wiley State Park, Prestonsburg — Thursday, April 23

MORNING SESSION

George P. Archer, M.D., Prestonsburg, President

Kentucky State Medical Association, presiding

9:00 a.m.*	**Registration**
9:15 a.m.	**Coffee Call**
9:45 a.m.	**Call to Order,** Doctor Archer **Invocation,** Reverend W. D. Jaggers, Pastor, Irene Cole Memorial Baptist Church, Prestonsburg **Welcome,** James Douglas Adams, M.D., Prestonsburg, president of the Floyd County Medical Society **Announcements,** Henry B. Asman, M.D., Louisville, KSMA secretary
10:00 a.m.	**"The Physician and Health Insurance",** Daniel F. Hanley, M.D., Brunswick, Maine, Editor of The Journal of the Maine Medical Association and Executive Director of the MMA.
10:30 a.m.	**"The Truth About King-Anderson",** Ernest B. Howard, M.D., assistant executive vice-president of the American Medical Association
11:00 a.m.	**Coffee Break**
11:10 a.m.	**"Fedicare and Politics",** Durward G. Hall, M.D., Springfield, Mo., Representative (Rep.) from Missouri to the United States House of Representatives
11:40 a.m.	**Stumping The Experts** The audience is requested to submit written questions

LUNCHEON SESSION

Doctor Archer presiding

12:30 p.m.	**"The Keys to Success and Happiness",** Mr. Clarence N. Walker, L.L.D., Atlanta, Georgia, Executive Staff Representative of the Coca-Cola Company

AFTERNOON SESSION

Delmas M. Clardy, M.D., Hopkinsville,

KSMA president-elect, presiding

1:45 p.m.	**"Free Enterprise or Disaster",** Nicholas Nyaradi, Ph.D., Peoria, Illinois, Director of the School of International Studies at Bradley University, and former Hungarian Finance Minister
2:15 p.m.	**Question And Answer Period** The audience is requested to submit written questions
3:00 p.m.	**Adjournment**

**All times listed Eastern Standard Time*


Doctor Hanley


Doctor Howard


Doctor Hall


Mr. Walker


Doctor Nyaradi

Daniel F. Hanley, M.D., Brunswick, Me., executive director of the Maine Medical Association and Editor of the Journal of the MMA, will be the first speaker of the day. His subject will be "The Physician and Health Insurance". Doctor Howard will follow Doctor Hanley on the program.

"Fedicare and Politics" will be the thought-provoking topic of Congressman Durward G. Hall, M.D., Springfield, Mo., who is currently serving his second term in the U.S. House of Representatives. Doctor Hall, a Republican and general surgeon, is a member of the House Armed Services Committee.

At the close of the morning session, the audience will be invited to submit written questions to the experts.

An interesting and lively formula for finding "The Keys to Success and Happiness" will be presented during the luncheon session by Clarence N. Walker, LL.B., Atlanta, Ga., Executive Staff Representative of the Coca-Cola Company and a much-sought-after lecturer.

Nicholas Nyaradi, Ph.D., director of the School of International Studies of Bradley University, Peoria, Ill., will speak after lunch on "Free Enterprise or Disaster". Former Hungarian Finance Minister Nyaradi, who was forced to Communist pressure to leave his native country, has become well known in this country through his books and speeches.

A second question and answer period will give the audience the opportunity to participate.

The Interim Meeting will adjourn at 3:00 p.m. Check-out-time at May Lodge at Jenny Wiley is normally at noon. However, special arrangements have been made for the extension of the time to around 3:30 p.m.

Doctor Archer, in discussing the Interim Meeting program, mentioned that the Board of Trustees of KSMA will meet in Wednesday, April 22, the day before the Interim Meeting. The session will be held at Jenny Wiley, beginning at 9:00 a.m.

That same evening, those arriving early for the Interim Meeting will be entertained with a musical program at the Lodge presented by the Patsy Teenagers, a group of talented youngsters from Prestonsburg. The program of modern, spiritual, and folk songs will be performed under the direction of Mrs. Kathryn Frazier, who also accompanies the group.

"Jenny Wiley will provide an ideal spot for the Interim Meeting, since it is easily reached from most areas of the state via the new Mountain Parkway, and has excellent modern facilities and spacious accommodations," Doctor Archer stated. He pointed out that the Park is at its loveliest in the Spring, when its thousands of flowering trees are beginning to bloom and the mountains are flooded with new greenery.

Commissioners Reappointed

Governor Edward T. Breathitt has recently reappointed three physicians to the State Tuberculosis Hospital Commission. Named by the Governor to serve additional four-year terms were: C. C. Howard, M.D., Glasgow, Boyce E. Jones, M.D., London, and Alex Spencer, M.D., West Liberty.

Unusual Entertainment Planned For Eve of Interim Meeting

A rare and refreshing treat is in store for Kentucky physicians and their wives on the eve of the KSMA Interim meeting at Jenny Wiley State Park, when The Patsy Teenagers, a choral group from nearby Prestonsburg, will entertain with a program of modern, spiritual, and folk songs.

This talented group, directed and accompanied by Mrs. Kathryn Frazier, has been invited to perform all over the United States. The singers are local high school children whose parents are connected with the Princess Elkhorn Coal Company, sponsor of the chorus.

The Patsy Teenagers will perform for KSMA members, their wives and guests, on the night of April 22, the evening before the 1964 KSMA Interim Meeting. You won't want to miss this sparkling entertainment!

First U.K. Senior Day Program Scheduled for April 14

The First Annual KSMA Senior Day for the University of Kentucky senior medical students has been scheduled for Tuesday, April 14, according to Donald Chatham, M.D., Shelbyville, Chairman of the KSMA Senior Day Committee.

The day's program will begin at 2:00 p.m., eastern standard time, in the Medical Center, with an address by George P. Archer, M.D., KSMA President. The evening session will be held at the Imperial House in Lexington where the U. of K. senior medical students will be guests of the individual members of the Fayette County Medical Society for a social hour and dinner.

Herbert Sloan, M.D., professor of surgery at the University of Michigan School of Medicine, will be the featured speaker at the evening session. The KSMA Senior Day program will be presented with the cooperation of the Fayette County Medical Society and the U. of K. Medical Center.

The Tenth Annual University of Louisville Senior Day, sponsored by KSMA in cooperation with the University of Louisville School of Medicine and the Jefferson County Medical Society, is scheduled for Monday, March 16. Harlan English, M.D., Danville, Ill., president of the Illinois State Medical Society, will address U. of L. Seniors that evening.

Remember to Register!

March 28 is the lost day for voter registration in Kentucky for persons wishing to vote in the up-coming primory elections. In order to register for the primary, o prospective voter must have been a resident of Kentucky for one year, ond a resident of his county for six months, prior to November 3, 1964, the date of the Kentucky general elections. As of this writing, the dote for the primary elections has not been definitely set.

The Kentucky Stote Medical Association wishes to stress the importance of voting, and to remind all its members who hove not alreody done so, to register before March 28.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193



Laman A. Gray, M.D., right, chairman of the KSMA McDowell Home Committee, is pictured accepting on behalf of the committee a rare early-19th Century Wedgewood pill tile, cutting machine, and pill rounder from Walter Bett, M.D., representing the Charles Pfizer and Company pharmacutical manufacturers, who made the gift to KSMA. The maceutical manufacturers, who gave the gift to KSMA. The set will be placed in the McDowell Home Apothecary Shop.

KSMA Accepts Rare Books and Tile For McDowell Home and Shop

The KSMA McDowell Home Committee, at a special luncheon meeting on January 18 at the Hunt Morgan House in Lexington, received two outstanding gifts for the McDowell Home. The Ephriam McDowell Library and a pill-tile, made in the early 19th century, were both considered very valuable additions to the Home.

The McDowell Library was presented to the Kentucky State Medical Association by Otto C. Brantigan, M.D., Baltimore, Md. Doctor Brantigan, a friend of the McDowell Home Committee's past chairman, Francis M. Massie, M.D., Lexington, came into possession of the McDowell Library through a patient of his, an Episcopal clergyman, Reverend Michael Barton.

Special guests and the press attended the January 18 ceremony when members of the committee opened the boxes containing the Library. Twenty-six books written in the early and middle 1700's were found in the box along with one hand-written notebook. The books are currently being stored in the Rare Book Section of the Transylvania College Library.

The rare Wedgewood pill-tile, cutting machine, and pill rounder, made in England in the early 1800's, was presented to the Kentucky State Medical Association by Charles Pfizer and Company, pharmaceutical manufacturers. Laman A. Gray, M.D., Louisville, chairman of the McDowell Home Committee, accepted the gifts on the behalf of KSMA from Walter Bett, M.D., representing Charles Pfizer and Company. The pill-tile, one of two such pill-tiles in the United States, will be placed in the McDowell Home Apothecary Shop.

Heart Disease Symposium Program Plans Released

The Tenth Annual Symposium on Cardiovascular Diseases will be held at the Brown Hotel in Louisville on March 27 and 28. The Symposium is co-sponsored by the Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine.

Jack L. Chumley, M.D., Louisville, president of the Heart Association Scientific Editor of Journal of KSMA and associate professor of medicine at U. of L., will preside at the Wednesday morning session.

Speakers and their subjects for the opening session are: Seymour H. Rinzler, M.D., head of the Cardiac Clinic of Beth Israel Hospital in New York City and physician in charge of the Anti-coronary club of the New York City Department of Health, "The Relationship of Nutrition to Coronary Artery Disease"; William L. Proudfit, department of cardiology of the Cleveland Clinic, Cleveland, Ohio, "Clinical Problems in Coronary Angiography "; Jeremiah Stamler, M.D., of the Heart Disease Control Program, director of the Division of Adult Health and Aging, and director of the Chicago Board of Health, "Basis for and Approach to the Primary Prevention of Premature Clinical Coronary Heart Disease".

A panel discussion on "Coronary Heart Disease", moderated by Doctor Chumley, will complete the morning program.

"Scenes of Cardiovascular Progress & You Are There" will be presented during the Luncheon session on Wednesday by J. Willis Hurst, M.D., professor and chairman of the department of medicine at Emory University School of Medicine in Atlanta.

Presiding at the afternoon session will be Grover B. Sanders, M.D., assistant clinical professor of medicine at the U. of L.

Wednesday Afternoon Program

Speakers at the Wednesday afternoon session and their subjects will be: Paul M. Zoll, M.D., associate clinical professor of medicine, Harvard University Medical School, and visiting physician and associate in medical research at Beth Israel Hospital in New York, "External Electric Countershock in the Treatment of Refractory Tachycardia"; Nelson R. Niles, M.D., associate professor of pathology at the University of Oregon School of Medicine, Portland, "The Clinical Application of Myocardial Histo-chemistry"; and Doctor Hurst, of Emory University, "The Trend in Management of Cardiac Arrhythmias".

"Treatment of Rhythm Disturbances", a panel discussion, will follow the individual presentations. Walter S. Coe, M.D., associate clinical professor of medicine, at the University of Louisville and associate Editor of Journal of KSMA will moderate.

From 8-9 a.m. on Thursday morning, Beverly T. Towery, M.D., professor and chairman of the department of medicine at the University of Louisville, will conduct Grand Rounds at Louisville General Hospital. All visitors are cordially invited to attend.

Robert L. McLendon, M.D., co-chairman of the

Symposium committee of the Heart Association and assistant clinical professor of medicine at U. of L., will preside at the Thursday morning opening session.

The following speakers and their subjects are scheduled for the Thursday morning session: E. S. Gurdjian, M.D., professor and chairman of the department of neurosurgery at Wayne State University College of Medicine, Detroit, "Treatment of Intracranial Aneurysms"; Jerre W. Lord, M.D., professor of clinical surgery at New York University Postgraduate Medical School, New York City, "Neurovascular Compression Syndromes of the Upper Extremities"; and Edward A. Edwards, M.D., associate clinical professor of anatomy at Harvard University Medical School, "Role of Lumbar Sympathectomy in Peripheral Arteriosclerosis".

A panel discussion, "Occlusive Vascular Diseases of the Head and Neck and Upper Extremities" will follow, moderated by J. Herman Mahaffey, M.D., clinical instructor in surgery at U. of L. and chairman of the Symposium committee of the Heart Association.

F. Albert Olash, M.D., clinical instructor in medicine at the University of Louisville, will preside over the Thursday afternoon session.

Speakers and their topics for Thursday afternoon include: John H. Moyer, M.D., professor and chairman of the department of medicine at Hahneman Medical College and Hospital, Philadelphia, "Management of Congestive Heart Failure"; James K. Alexander, M.D., associate professor of medicine at Baylor University College of Medicine in Houston, "Obesity and The Heart"; and Nelson R. Niles, M.D., associate professor of pathology at the University of Oregon Medical School, Portland, "Coronary Angiography, Surgery and Pathology—Post Mortem Studies".

Closing the program will be a panel discussion featuring questions on the entire session, entitled, "What's Your Question?", moderated by Doctor Towery.

Doctor McLendon, co-chairman of this year's Symposium committee, has been named to head the committee for the 1965 Cardiovascular Symposium.

Dr. Segerberg Will Serve On S.S. HOPE Mission

Ludwig H. Segerberg, M.D., Louisville neurosurgeon, has been appointed to the second rotation team of the teaching-training hospital ship S.S. HOPE, and left at the end of February for Guayaquil, Ecuador to join the vessel's medical staff.

Doctor Segerberg, an associate clinical professor of medicine at the University of Louisville School of Medicine, is one of 37 physicians and dentists who comprise the second team of rotators aboard the ship. Rotators serve without pay for periods of one to two months and augment the permanent corps of more than 80 physicians, nurses, and paramedical personnel.

Doctor Segerberg is the first Louisville physician to serve on the S.S. HOPE. Over 600 members of the medical profession have been attached to the floating medical center since 1960.

Industrial Medical Association Releases Meeting Program

A variety of occupational medical problems will be discussed for the members of the Kentucky Industrial Medical Association at its April 2 meeting at the Holiday Inn N.E. in Louisville.

The following program was released by F. P. Shepherd, M.D., Louisville, president of the association:

1:30 p.m.	**Registration**
2:00 p.m.	**"Education and the Modern Physician,"** Donn L. Smith, M.D., Dean of the University of Louisville School of Medicine
2:30 p.m.	**"Alcoholism—Outpatient Treatment",** Bruce Skaggs, clinical director, Outpatient Treatment Center, Louisville-Jefferson County Council on Alcoholism
3:00 p.m.	**"Postgraduate Psychiatric Training for Occupational Physicians",** Frederick C. Ehrman, M.D., assistant professor of psychiatry, University of Louisville School of Medicine
3:30 p.m.	**Coffee Break**
3:45 p.m.	**"Practical Management of Acute Poisonings",** Rudolph J. Muelling, M.D., professor of pathology, University of Kentucky College of Medicine
4:15 p.m.	**"Stimulating Interest in Occupational Health Among Medical Students",** Kurt W. Deuschle, M.D., professor and chairman, department of community Medicine, University of Kentucky College of Medicine
4:45 p.m.	**"Cardiac Emergencies in the Plant",** John L. Wolford, M.D., instructor in medicine, University of Louisville School of Medicine

At 5:15 a social hour will conclude the scientific session, followed by dinner at 6:00 p.m. Entertainment films will be shown after the dinner.

Mental Health Congress Slated For May 14 in Louisville

The first Kentucky Congress on Mental Health sponsored by the Kentucky State Medical Association in cooperation with the Kentucky Psychiatric Association and the State Department of Mental Health, will be held Thursday, May 14, at the Kentucky Hotel, Louisville, from 9:00 a.m. to 3:30 p.m., EST.

Frank M. Gaines, M.D, Louisville, Chairman of the KSMA Mental Health Committee, said the purpose of the conference is to report on the appropriations approved by the 87th Congress for comprehensive mental health studies and to establish guidelines that should be pursued in mental health planning by KSMA in the months and years ahead.

Participants in the congress will be limited and all KSMA members desiring to attend are urged to notify the KSMA Headquarters Office.

NEW MEN'S SHOP



. . . in our NEW SOUTHERN
OPTICAL BUILDING, 640 S. 4th St., between
Broadway and Chestnut . . . where a man is king.
In its masculine surroundings, you'll experience
the same comfort while being fitted for
glasses as you do when being fitted for clothes.

GUILD OPTICIANS
Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees. ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication. beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit)

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective **GERIATRIC** antiarthritic with

REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention... the enteric coating assures gastric tolerance... and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate-SF

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium para-aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe
PABALATE-SODIUM FREE

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Lexington Clinic Conference Offers Varied Program

"Viral Diseases of the Kidney" will be the topic of a discussion by John P. Utz, M.D., Bethesda, Md., Chief of Infectious Disease Service of the National Institutes of Health, who will speak before the Lexington Clinic Spring Conference on Wednesday, April 1.

C. Richard Gill, M.D., of the Lexington Clinic staff and chairman of the conference committee, released the following full program:

9 a.m.: Registration and Welcome

Seminar on Peptic Ulcer

C. H. Fortune, M.D., Moderator

1. *Pain Patterns* — C. R. Gill, M.D.
2. *Unusual Features* — D. H. Johnston, M.D.
3. *Diagnostic Techniques* — B. E. Watson, M.D.

Intermission

4. *Problem Cases* — Panel Discussion

Participants: B. E. Watson, M.D., D. H. Johnston, M.D., E. Todd, M.D., R. D. Floyd, M.D., and R. C. Quillin, M.D.

Viral Diseases of the Kidney

John P. Utz, M.D.

Luncheon with Round Table Discussion

2 p.m. A. L. Cornish, M.D., Moderator

A Pilot Study of TB Eradication in Kentucky

Kurt W. Deuschle, M.D., Professor and Chairman, Department of Community Medicine, University of Kentucky College of Medicine.

Backache—Not What it Seems—P. H. Jones, M.D.

Weak Muscles—J. C. Malek, M.D.

Intermission

What's New in Retinal Detachment—W. B. Snyder, M.D.

Investigation of a New Antibiotic, Cephalothin—W. E. Herrell, M.D.

Discussion and Closing Comments

All the physicians participating in the conference are on the staff of the Lexington Clinic, with the exception of Doctors Utz and Deuschle.

Kentucky Thoracic Society Plans April 23 Meeting

Nationally known authorities on tuberculosis, emphysema, and bronchitis will speak at the Kentucky Thoracic Society's Annual Meeting April 23, according to information released recently by Grover Sanders, M.D., Louisville, society president, and William H. Anderson, M.D., Louisville, program chairman.

Coming from out of state to address the sessions, to be held at the Rankin Amphitheater at Louisville General Hospital, will be Edith Lincoln, M.D., professor of pediatrics at New York University School of Medicine; Ross McLean, M.D., Emory University, Atlanta, Ga.; and Herman Wechsler, M.D., of the College of Physicians and Surgeons of Columbia University.

Other guest speakers are Jerome Kleinerman, M.D., of St. Luke's Hospital in Cleveland, Ohio, and Ben Burrows, M.D., of the University of Chicago. The Thoracic Society, the medical branch of the Kentucky Tuberculosis Association, will hold its meeting in conjunction with the Annual Meeting of the TB Association, which is to be held April 23-24 at the Sheraton Hotel in Louisville. All physicians are invited to attend the sessions.

Top KSMA-AMA Leaders To Speak At KHA Meeting—Mar. 30-Apr. 2

Milford O. Rouse, M.D., Dallas, Tex., speaker of the House of Delegates of the American Medical Association, and George P. Archer, M.D., Prestonsburg, president of the KSMA, will be two of the featured speakers at the Kentucky Hospital Association's Annual Meeting being held March 30-April 2 at the Kentucky Hotel in Louisville.



Doctor Rouse

Doctor Rouse, whose topic at the membership luncheon on April 1 will be "Physicians and Hospitals as Partners on The Health Team", is active in the affairs of the Texas Medical Association, and was vice-speaker of the AMA House for several years before his election as speaker last June.

Doctor Archer will participate in a Wednesday Afternoon panel discussion on "Resources Available for Assurance of Proper Patient Care and Treatment". Also on the program are Charles C. Edwards, M.D., Chicago, assistant director of the Division of Environmental Medicine and Medical Services of the AMA, and Carl C. Cooper, M.D., Carrollton, KSMA vice-president (Eastern).

Other Kentucky physicians taking part in the meeting are:

James B. Holloway, M.D., Lexington, chairman of the KSMA Hospital Committee, and Fred C. Rainey, M.D., Elizabethtown, president of the Kentucky Junior Chamber of Commerce, will also participate in the meeting. Other physicians taking part in the program are Thomas A. Courtenay, M.D., coordinator of the Louisville Poison Control Center; and Russell E. Teague, M.D., Frankfort, Commissioner of the Kentucky State Department of Health.

Sixth District Society Elects

Carlisle Dodson, M.D., Russellville, was elected president of the Sixth Trustee District Medical Society in a meeting February 11 at the Western Hills Restaurant in Bowling Green. John Burris, M.D., Morgantown, was chosen as vice-president, and Paul J. Parks, M.D., Bowling Green, secretary.

Herbert N. Harkleroad, M.D., Bowling Green, presented a scientific discussion on chronic diarrhea. Rex Hayes, M.D., Glasgow, was introduced as new KSMA Trustee from the Sixth District.



ACHROCIDIN®

TETRACYCLINE HCl-ANTIHISTAMINE-ANALGESIC COMPOUND

Each Tablet contains:

ACHROMYCIN® Tetracycline HCl	125 mg.
Acetophenetidin (Phenacetin)	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Each (5 cc.) Teaspoonful of Syrup (lemon-lime flavored) contains:

ACHROMYCIN® Tetracycline equivalent to Tetracycline HCl	125 mg.
Acetophenetidin (Phenacetin)	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben 4 mg.; Propylparaben 1 mg.	

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms, tooth discoloration. The last named may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Average Adult Dosage: 2 Tablets or 2 Teaspoonfuls of Syrup four times daily The total average daily dosage for children, determined by the tetracycline content, is 10 to 20 mg. per pound body weight, divided into four equal doses.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

7143-3

Lederle

News Items

Jeremiah T. Flowers, M.D., has announced the opening of his offices in Louisville for the practice of ophthalmology, in association with **Thomas E. Campbell, M.D.** Doctor Flowers, who graduated in 1958 from the University of Louisville School of Medicine, interned at Tampa General Hospital in Tampa, Fla., and was a resident at the University of Louisville Hospitals from 1960 to 1963. He was a Fellow at Johns Hopkins Hospital and Washington Hospital Center from 1963-64.

Inez L. Ice, M.D., has become associated with **Warren M. Cox, M.D.,** and **John Ice, M.D.,** in Louisville, where she will limit her practice to psychiatry. Doctor Ice, a 1953 graduate of George Washington University School of Medicine, interned at the U. S. Public Health Service Hospital in Seattle, Wash., and was a resident at the USPHS Hospital in Lexington, Ky., and at Fort Worth, Tex., and Louisville.

Elias E. Kawas, M.D., has become associated with the Trover Clinic in Madisonville, where he will limit his practice to pathology. A native of Honduras, Doctor Kawas graduated in 1953 from New York University School of Medicine, and interned at Kings County Hospital in Brooklyn. His residency was completed at Walter Reed Army Hospital in Washington, D.C.

Arthur T. Hall, M.D., Madisonville, has become associated with the Trover Clinic in that city for the practice of pediatrics. A 1952 graduate of the University of Rochester School of Medicine, Doctor Hall interned at Robert Packer Hospital, and completed his residency there. He was previously in private practice in Corning, N.Y.

Leslie Van Nostrand, M.D., medical director at General Electric Appliance Park in Louisville, recently announced his resignation for the purpose of entering a psychiatry residency at White Plains, New York. Doctor Van Nostrand, who is chairman of the Louisville and Jefferson County Council on Alcoholism and assistant clinical professor of occupational medicine at the University of Louisville, plans to return to Louisville at the end of his residency.

James B. Holloway, M.D., Lexington, was elected secretary and treasurer of the Midwest Hunt Race Association at the February 1 meeting of the association at the Iroquois Hunt Club near Lexington. The group sponsors the annual Oxmoor Steeplechase in Louisville, which will be held this year on May 23.

Edwin H. Hanekamp, M.D., Owensboro, has opened an office in that city for the practice of obstetrics and gynecology. A 1956 graduate of the St. Louis University Medical School, Doctor Hanekamp interned at St. Louis City Hospital and completed his residency there.

Albert C. Esposito, M.D., Huntington, W. Va., will chair the section of Ophthalmology of the Southern Medical Association when it meets in Memphis November 16-19, 1964.

J. C. Rosenberg, M.D., Lexington, has joined the staff of the University of Kentucky College of Medicine. A surgeon, Doctor Rosenberg graduated in 1954 from the University of Chicago Medical School. His internship and residency were completed at the University of Minnesota Hospitals.

John T. Teegen, M.D., has become associate with the Denham Medical Clinic in Maysville for the general practice of medicine. A native of Davenport, Iowa, Doctor Teegan graduated in 1960 from the State University of Iowa School of Medicine, and interned at Broadlawns Polk County Hospital in Des Moines.

Clyde J. Nichols, M.D., Clarkson general practitioner, was the winner of the $100 second prize for woodland improvement in the eighth annual Tom Wallace Farm Forestry Awards contest sponsored by the Courier-Journal, the Louisville Times, and WHAS, Inc. Doctor Nichols, who is president of the Grayson County Medical Society, is mayor of Clarkson.

Helen M. Deane, M.D., has joined the staff of Berea College in Berea, Kentucky, where she will practice in connection with the Student Health Service. Doctor Deane, who received her M.D. from the University of Minnesota School of Medicine in 1921, interned at Women's Hospital of Philadelphia. She has previously been in practice in South Carolina, North Carolina, Alabama, Minnesota, and New York.

Arvis Porter, M.D., has entered the practice of general medicine at Morehead. Doctor Porter, a 1962 graduate of the University of Louisville School of Medicine, is a native of Elliott County. He interned at St. Elizabeth's Hospital in Dayton, Ohio.

Wayne Gordon, M.D., has joined the faculty of the University of Kentucky College of Medicine, where his major duties will be connected with the University Health Service. An internist, Doctor Gordon graduated from the University of Chicago school of Medicine in 1930, and interned at the Presbyterian Hospital in Chicago. Before coming to the University of Kentucky, Doctor Gordon was an associate professor of medicine at the Christian Medical College at Vellore, Madras State, India.

Thomas E. Lester, M.D., has become associated with the Cumberland Valley Medical Association at Lynch, Kentucky, where he will practice general medicine. A 1962 graduate of the University of Tennessee School of Medicine at Memphis, Doctor Lester interned at Roanoke Memorial Hospital in Roanoke, Va.

George S. Allen, Jr., M.D., has opened an office in Jeffersontown for the general practice of medicine. A 1951 graduate of the University of Louisville School of Medicine, Doctor Allen interned at the Ohio State University Hospitals, and was a psychiatric resident at Tulane University in 1961-62. From 1952-61 he was in general practice in Louisville.



release for hostility?

Overeating is often an outlet for feelings of hostility. Many people take out their anger by overindulgence at or between meals. As a result they become overweight.

'Eskatrol' *Spansule* capsules both control appetite and relieve the emotional stress that causes overeating. That's why so many patients are losing more pounds with 'Eskatrol'.

ESKATROL® Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

SPANSULE®

brand of sustained release capsules

because emotions play an important role in overweight

Brief Summary of Principal Side Effects and Cautions

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory. *Cautions:* 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

For complete prescribing information, please see *PDR* or available literature.

Supplied: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F

KAGP Plans Annual Meeting In Louisville May 6-8

Top guest speakers from all sections of the country will be featured on the program of the Kentucky Academy of General Practice Annual Meeting to be held at the Kentucky Hotel in Louisville May 6-8.

Among the medical authorities scheduled to appear before the Academy are: Charles S. Petty, M.D., Baltimore, pathologist, who will speak on "Sudden Unexpected Death" and "Therapeutic Misadventure"; Satoru Nakamoto, M.D., Cleveland, Ohio, whose topic will concern renal transplantation; and Don W. Chapman, M.D., Houston, Tex., who will discuss advances in cardiology.

Other speakers and their topics will include: Robert D. Currier, M.D., Jackson, Miss., neurologist, whose subjects will be seizure control and peripheral neuropathy; and Harry N. Hoffman, M.D., Mayo Clinic, Rochester, Minn., who will discuss diseases of the liver. In many cases complete information is not yet available.

A full program of the meeting, including speakers and titles of papers, as well as biographical material on the speakers, will be carried in the April issue of The Journal.

Dr. Gardner Speaks for AMPAC At Meetings Across U.S.

Hoyt D. Gardner, M.D., Louisville, representing the American Medical Political Action Committee, is currently addressing various medical groups across the country on "Political Action at the State Level by Doctors" in an effort to arouse more political interest and action at the grass roots level of the medical profession.

Doctor Gardner, who is chairman of the Board of Directors of the Kentucky Educational Medical Political Action Committee (KEMPAC), is a member of the Speakers Bureau of AMPAC.

The Frederick County, (Maryland) Medical Society heard Doctor Gardner speak on this subject on March 18 before a regular meeting of the society at Frederick, Md. The same topic will be presented by the KEMPAC head in Atlanta on March 21 when he is the guest of the AMPAC Regional Workshop for Southern States at the Atlanta Biltmore Hotel. On April 4 the Northeastern States AMPAC District will meet at the Americana Hotel in New York City with Doctor Gardner as guest speaker.

Writing Award Offered Students

A competition for a $250 award for the best manuscript submitted by a medical student, intern, or resident on any subject pertinent to and concerning occupational health, has been announced by the Central States Society of Industrial Medicine and Surgery. The contest closes at midnight July 31, 1964. For information write to Industrial Medical Association, 55 East Washington Street, Chicago, Ill. 60602.

Medical School News

U.K. Gets $784,805 Grant For Research Center

The University of Kentucky College of Medicine has received a grant of $784,805 from the National Institutes of Health to establish a 10-bed clinical research unit at the Medical Center.

E. D. Pellegrino, M.D., chairman of the department of Medicine, will supervise research, and William W. Winternitz, M.D., associate professor of medicine, will be program director.

The funds will be used for the study of diseases and physical disorders under carefully controlled conditions. The grant is the first of several expected to finance the new research center for seven years.

Editorial Praise

In a February 1 editorial, the Louisville Courier-Journal and Times praised the University of Kentucky Medical Center for its prominent role in recent progresssive medical programs within the state, its wide acclaim, in spite of its comparative newness, as a teaching and training center, and its recognition as a research center, as evidenced by the recent National Institutes of Health grant for clinical research.

U. of L. Placque Honors Dr. and Mrs. Price

John W. Price, Jr., M.D., retired Louisville Surgeon, and Mrs. Price, who together established a $200,000 surgical-research fund at the University of Louisville School of Medicine, were honored January 17 at the dedication of a placque at the entrance of the new U. of L. Medical-Dental Research Building.

The fund, initiated in 1957 with a $25,000 contribution by the Prices, was established in memory of their forebears, medical and civic leaders in Louisville.

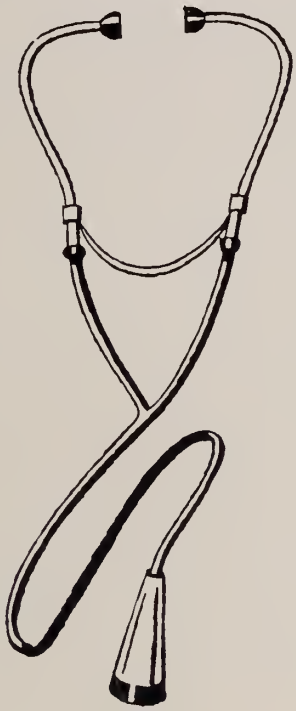
$43,900 in Grants Received

Grants totaling $43,900 have been awarded in two separate grants to University of Louisville Medical School Researchers.

The National Science Foundation recently gave a $37,900 grant to Sheppard M. Walker, Ph.D., professor of physiology, to study muscle contraction in fish and frogs. High-speed photography will be used in the study.

A $6,000 grant from the Kentucky Lions Eye Foundation was given to the department of Ophthalmology of the U. of L. School of Medicine to be used in clinical and research programs.

The U. of K. Medical Center has been included by the American Dental Association and the World Health Organization on a list of "places to see" for foreign visitors.



RECOMMEND

BLUE SHIELD . . . THE UNIQUE MEDICAL-SURGICAL PREPAYMENT PLAN . . . ORGANIZED BY DOCTORS FOR PEOPLE . . . TO HELP THEM VOLUNTARILY BUDGET IN ADVANCE FOR CARE

Blue Shield and its companion Hospital Protection Plan, Blue Cross, have never cancelled membership because of age, health, retirement, or an incurable physical condition.

BLUE SHIELD KENTUCKY PHYSICIANS MUTUAL, INC.

BLUE CROSS BLUE CROSS HOSPITAL PLAN, INC.

3101 BARDSTOWN ROAD — LOUISVILLE, KY.
PHONE GL 2-1511



Richard F. Greathouse, M.D., Louisville pediatrician and former president of the Collie Club of America, has been elected to the Canine Division of Morris Animal Foundation of Denver. Also past president of the Kentucky Collie Club, he is a breeder of Collies and frequent judge of shows.

Thirteenth Trustee District Meeting Set April 7 in Ashland

The 13th KSMA Trustee District will have its annual Trustee District Meeting at the Henry Clay Hotel in Ashland, Tuesday, April 7, 1964.

Clyde Sparks, M.D., Ashland, Trustee for the 13th District, announced that KSMA President George P. Archer, M.D., Prestonsburg, will be the featured speaker.

The dinner meeting will begin at 6:30 p.m., EST, preceded by a social hour scheduled for 6:00 p.m. All KSMA members in the district will receive personal invitations to the meeting. Wives are also invited and urged to attend.

Dr. Witten Speaks in Memphis

Carroll L. Witten, M.D., Louisville, addressed the Diamond Jubilee (75th) annual meeting of the Mid-South Postgraduate Medical Assembly in Memphis on February 13. Doctor Witten spoke on two subjects: "Cholesterol—Fact or Fiction", and "The Current Status of the Rh Factor".

TB Project Gets Director

Michael L. Furcolow, M.D., a nationally-known authority on tuberculosis and histoplasmosis, has been named director of the tuberculosis eradication project in Martin County, Kentucky. Doctor Furcolow is currently chief of the Kansas City Field Station, Department of Health, Education and Welfare, Communicable Disease Center.

Dr. Clardy to Address Students

KSMA president-elect Delmas M. Clardy, M.D., Hopkinsville, will speak to an Area Conference of pharmacy students of the National Pharmacy Student Association in Lexington on Saturday, February 29, according to James M. Brockman of the University of Kentucky Pharmacy School, secretary and treasurer of the Region IV Student Pharmacy Association.

"Here We Go Again," will be the topic of Doctor Clardy's address on the subject of the mutual problems of medicine and pharmacy in regard to Medicare. The three-day meeting of representatives from pharmacy schools in Kentucky, Illinois, Ohio, Indiana, Michigan, Wisconsin is expected to attract approximately 150 future pharmacists from these schools.

Ky. Surgical to Meet in April

Three outstanding guest speakers from other states will be among those addressing the scientific sessions of the Annual Meeting of the Kentucky Chapter, American College of Surgeons when it meets April 24 and 25 at the Stouffer Louisville Inn.

Among the authorities due to speak at the meeting are: Francis B. Carter, M.D., head of the department of obstetrics and gynecology at the Duke University School of Medicine, Durham, N.C.; George Crile, Jr., M.D., a member of the surgical staff of the Cleveland Clinic, Cleveland, O.; and Thomas B. Quigley, M.D., Boston orthopedic surgeon and assistant clinical professor of surgery at Harvard Medical School. A more complete program with a full list of speakers is to be carried in a later issue of The Journal.

SMA Elects Dr. Hancock Trustee

J. Duffy Hancock, M.D., Louisville surgeon, was elected as a Trustee of the Southern Medical Association during the SMA Annual Meeting held in New Orleans November 18-21. Doctor Hancock was named to fill the unexpired term of A. Clayton McCarty, M.D., Louisville, who died in August.

Doctor Hancock, who is chairman of the KSMA Memorials Commission, was president of KSMA in 1954. A 1921 graduate of the University of Louisville School of Medicine, he has been a delegate to the American Medical Association from KSMA, and has served in many other capacities.

Dr. Asman on Executive Council

Henry B. Asman M.D., KSMA Secretary, was elected a member of the Executive Council of the Ohio Valley Proctologic Society at the Society's January 27 meeting in Cincinnati. J. M. McIntyre, M.D., Indianapolis, and Walter J. Tims, M.D, Youngstown, Ohio, were also named to the council.

Other officers elected at the meeting at the Medi-Club (Academy of Medicine) were: A. Gerson Carmel, M.D., Cincinnati, president; Stewart R. Jones, M.D., president-elect; and Jack D. Selzer, M.D, secretary-treasurer, all of Cincinnati. The next meeting of the Society is scheduled for April 17 in Cincinnati.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

(Research and Teaching Exhibits)

1964 Annual Meeting — Kentucky State Medical Association

Convention Center — **Louisville, Kentucky** — **Sept. 29, 30; Oct. 1**

Fill Out and Mail to:

BENJAMIN B. JACKSON, M.D., Chairman

Committee on Scientific Exhibits

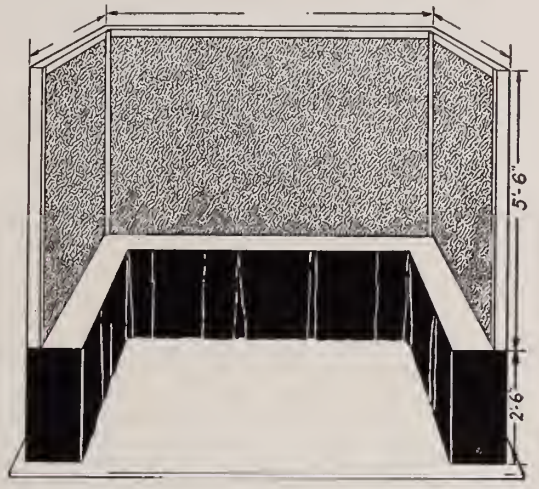
Kentucky State Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1964

Dimensions and structure of KSMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....

   .....

   Institution (if desired): .....

   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

   Charts and Posters.... Photographs.... Drawings.... X-rays....

   Specimens.... Moulages.... Other Material ..... (Describe)
6. Booth Requirements:

   Amount of wall space needed? .....

   Back wall ..... Side walls (All side walls are 4') .....

   Square feet needed? ..... Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

Signature of Applicant

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KSMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

In Kentucky

MARCH

12	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
12-14	Hematology, University of Kentucky, Lexington, Ky.
19	University Surgery Day, University of Kentucky, Lexington, Ky.
25-26	Kentucky Heart Association, Louisville, Ky.
27	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.
30-April 2	Kentucky Hospital Association, Louisville, Ky.

APRIL

1	9th Annual Clinical Conference, Lexington Clinic, Lexington, Ky. Difficult Problems in Treatment of Peptic Ulcer and A Pilot Study of TB Eradication in Kentucky.
2	Kentucky Industrial Medical Association, Holiday Inn, N.E., Louisville, Ky.
5-8	Kentucky Dental Association, Louisville, Ky.
7	KSMA 13th Trustee District Meeting, Ashland, Ky.
9	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
14-16	Kentucky Public Health Association, Kentucky Hotel, Louisville, Ky.
20	Southern Society of Clinical Surgeons, University of Kentucky Medical Center, Lexington, Ky.
21	Southern Society of Clinical Surgeons, University of Louisville, Louisville, Ky.
22	Southern Society of Clinical Surgeons, St. Joseph's Hospital, Lexington, Ky.
23	KSMA Interim Meeting, Jenny Wiley State Park, Prestonsburg, Ky.
24	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.

MAY

6-8	Kentucky Academy of General Practice, Kentucky Hotel, Louisville, Ky.
13	KSMA 12th & 15th Trustee Districts Meeting, Somerset, Ky.
13-14	Kentucky Pediatric Society, Medical Arts Building, Louisville, Ky.
14	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
14	Kentucky Mental Health Congress, Kentucky Hotel, Louisville, Ky.
14	KSMA 4th Trustee District Meeting, Bardstown, Ky.

Surrounding States

MARCH

16-28	Anatomical and Clinical Otolaryngology, Indiana University, Indianapolis, Ind.
18	Clinical Allergy, Ohio State University, Columbus, Ohio.
18-19	Hypertension and Renal Diseases, Cleveland Clinic Educational Foundation, Cleveland, Ohio.
18-19	Obstetrics and Gynecology, Indiana University, Indianapolis, Ind.

APRIL

1-3	Pediatric Advances—1964, Ohio State University, Columbus, Ohio.
1-3	American Surgical Association, Hot Springs, Va.
3-5	American Society of Internal Medicine, Atlantic City, N.J.
6-10	American College of Physicians, Atlantic City, N.J.
11-16	American Academy of General Practice, Atlantic City, N.J.
13-16	Industrial Medical Association, Pittsburgh, Pa.
16	2nd Annual Seminar on Premature Care, Good Samaritan Hospital, Cincinnati, Ohio.
22	Non-Tuberculous Pulmonary Disease, Marion County General Hospital, Indianapolis, Ind.
29-May 3	Student AMA, Sherman House, Chicago, Ill.

Clinical Surgeons Meeting Set

All Kentucky surgeons are cordially invited to attend the meeting of the Southern Society of Clinical Surgeons, which will be held at the University of Kentucky Medical Center on April 20, at the University of Louisville School of Medicine on April 21, and at St. Joseph's Hospital in Lexington on April 22, 1964. The Campbell House in Lexington will be the headquarters for the meeting, and further information may be obtained from Nicholas J. Pisacano, M.D., Director, Continuation Medical Education, University of Kentucky Medical Center.

ECG Course to be Held at U.K.

The University of Kentucky Medical Center has announced a course in electrocardiography on nine consecutive Friday evenings from 7:30 p.m. to 9:30 p.m., EST, April 3-May 29, 1964. Registration fee for the nine sessions is $25. Application has been made for Category I, American Academy of General Practice credit. Registration and inquiries should be directed to Nicholas J. Pisacano, M.D., Director, Continuation Medical Education, at the Medical Center in Lexington.

FOR SALE

Physician's waiting room furniture, consultation room equipment, and three treatment rooms fully equipped, all purchased in the last eight years.

Two-story brick veneer building, excellent physician's office on the first floor, modern attractive four-room apartment on the second floor, finished basement.

Stair glide purchased new, used only two months — bargain.

Write: J. O. Mattox, M.D.
903 Highland Avenue
Carrollton, Ky.

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®
parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey
Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
203 Parkside Building, 4140 Shelbyville Road, Louisville 7
Mailing Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK®



NEO-VADRIN

FOR NASOSINUSITIS

NEO-VADRIN is the deep nasal decongestant that restores drainage and ventilation of all eight sinuses by opening up the obstructed ostia.

The therapeutic effect is both prompt and prolonged. Hence Neo-Vadrin is ideal for treatment of deep nasal and sinus congestion due to head colds, hay fever, vasomotor rhinitis, nasal allergy, and sinusitis.

In addition, Neo-Vadrin is antiseptic and locally anesthetic. May be used by patients of all ages.

[1]Sollmann's Manual of Pharmacology, 8th ed., 1957, p. 507.
[2]Modern Drug Encyclopedia, 7th ed., 1958, p. 757.

NEO-VADRIN CONTAINS:

dl-Norephedrine HCl	0.4%
Phenylephrine HCl	0.15%
Chlorobutanol	0.15%
Benzalkonium Chloride	0.005%

The more prolonged action of dl-norephedrine[1] combined with promptly effective phenylephrine[2] provides a long span of hours for more satisfactory therapeutic response.

Supplied in 1 fld. oz. dropper bottles with special nasal applicator and ¾ oz. plastic spray bottles.

Samples are available to physicians upon request. Please make your request on your prescription sheet or letterhead.

First Texas *Pharmaceuticals, Inc.*

DALLAS • SINCE 1901



County Society Reports

Adair

George O. Nell, M.D., was elected president for the coming year of the Adair County Medical Society at their regular meeting February 3 at Columbia. W. Todd Jeffries, M.D., was chosen secretary of the group, and M. C. Loy, M.D., was named delegate to the KSMA. James C. Salato, M.D., was named alternate delegate All the officers are from Columbia.

Fayette

T. R. Bryant, M.D., Lexington, was named president-elect of the Fayette County Medical Society at the January 14 meeting of the society held at Good Samaritan Hospital.

He will take office in 1965, replacing Andrew M. Moore, M.D., 1964 president, who was installed at the same meeting. Other officers elected for 1964 are: C. Edward Rankin, M.D., vice president, and John F. Berry, Jr., M.D., secretary-treasurer.

Henderson

Douglas M. Haynes, M.D., professor and chairman of the department of Obstetrics and Gynecology at the University of Louisville School of Medciine, presented the scientific program at the January 13 meeting of the Henderson County Medical Society held at the Soaper Hotel in Henderson.

Jefferson

Roy H. Moore, Jr., M.D., Louisville, was chosen president-elect of the Jefferson County Medical Society at the January 20 society meeting at the Medical Arts Building in Louisville. A surgeon, Doctor Moore will take office in 1965.

New officers serving the society in 1964 are: George A. Sehlinger, M.D., president; Rudy J. Ellis, M.D., and Henry G. Saam, M.D., vice presidents; Walter I. Hume, Jr., M.D., secretary; Richard L. Roth, M.D., treasurer; and John P. Bell, M.D., J. Duffy Hancock, M.D., and Bernard I. Popham, M.D., members of the judicial council.

At the same meeting the society presented its annual Lay Award of Merit to Kenneth F. Rowland, news director of radio station WKLO, for the station's presentation of the alcoholism problem. Members donated 106 pints of blood to the Blood Bank prior to the meeting.

Madison

Dwight L. Blackburn, M.D., Berea, was elected 1964 president of the Madison County Medical Society at a recent meeting, according to information released by William D. Epling, M.D., Berea, new secretary-treasurer.

Other officers named to serve in 1964 are: R.

Eugene Bowling, M.D., Richmond, vice president; William G. Clouse, M.D., Richmond, and Doctor Epling, delegates to the Kentucky State Medical Association; and Clifford F. Kerby, M.D., Berea, and John A. Wimberly, M.D., Richmond, alternate delegates.

McCracken

O. D. Maxey, M.D., Paducah, was named president of the McCracken County Medical Society for the year 1964 at the December 18 annual meeting of the society at Boswell's Restaurant in Paducah. He succeeds B. A. Washburn, M.D., Paducah, as president.

Other officers elected for 1964 include: L. D. Myre, M.D., vice president; and Vernon D. Pettit, M.D., secretary-treasurer. Both are from Paducah. Theodore T. Myre, M.D., Paducah, was named a new delegate from the society to the Kentucky State Medical Association.

Mercer

New president of the Mercer County Medical Society for 1964 is Ralph T. Ballard, M.D., Harrodsburg, who was elected at the January 9 meeting in Harrodsburg.

E. H. John, M.D., Harrodsburg, was named vice president of the society, and C. B. VanArsdall, Jr., M.D., Harrodsburg, was elected secretary-treasurer. John S. Baughman, M.D., was named as a delegate to the Kentucky State Medical Association, and Doctor Ballard was chosen as an alternate delegate.

Nelson

James M. Millen, M.D., Bardstown, has been chosen president of the Nelson County Medical Society for 1964, succeeding Kenneth Stinnett, M.D., of Bardstown. Also elected were: Patrick J. Murphy, M.D., Lebanon Junction, vice-president, and E. W. Wood, M.D., Bardstown, secretary.

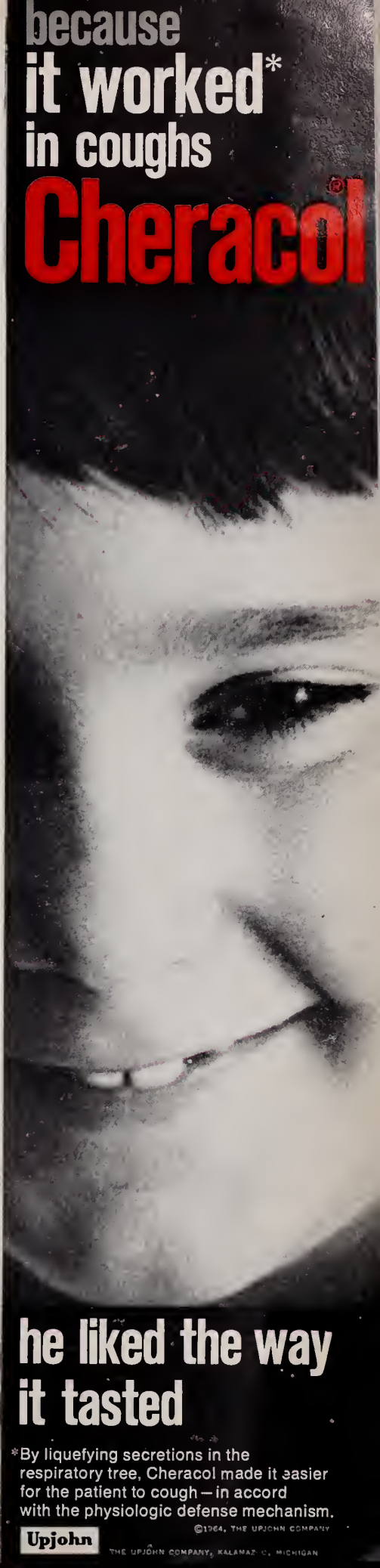
Perry

New officers for the coming year were recently elected by the Perry County Medical Society at a meeting at Hazard. Chosen as 1964 president was Eugene Carter, M.D., Hazard. Vice-president Eli C. Boggs, M.D., and Charles C. Rutledge, M.D., secretary-treasurer, are also from Hazard.

Warren-Edmonson-Butler

Richard F. Grise, M.D., Bowling Green, was named president of the Medical Societies of Warren, Edmonson, and Butler counties at a joint meeting of the tri-county group held January 14 in Bowling Green.

M. Harper Wright, M.D., was chosen vice-president, Richard Beaven, M.D., secretary, and Carroll Brooks, M.D., treasurer. All are from Bowling Green.



KSMA Council and Committee Reports

Council on Communications and Public Service

N. Lewis Bosworth, M.D., Lexington, Chairman

Louisville **January 23, 1964**

Representatives from the American Medical Association staff were present at the last meeting of the Council on Communications and Public Service to explain the services available to the council from the AMA Communications Division.

The council, by common consent, recommended that the KSMA endorse commercial advertising concerning public service programs in medicine and approved exhibits for the 1964 State Fair and KSMA Annual Meeting.

The council officially named the Mandatory Indoctrination Program, approved by the 1963 meeting of the House of Delegates, the "Mandatory Orientation Course," and appointed a subcommittee to formulate the methods of implementation of the course. Guidelines will be submitted to the Board of Trustees for use in the drafting of the Bylaws.

The council also recommended to the Board of Trustees the duties of the committees serving under the council for consideration as additions to the Bylaws, and recommended that shades be purchased for the Board Room to make it suitable for the projection of movies or slides.

Emergency Medical Services Committee

William T. Rumage, Jr., M.D., Louisville, Chairman

Louisville **January 16, 1964**

The Emergency Medical Services Committee recommended to the Board of Trustees that the name of the committee be changed to Committee on Disaster Medical Care to correspond with the AMA and other state medical associations.

Members of the committee reviewed the special issue of the KSMA Journal on Disaster Medical Care and expressed their appreciation to all those who contributed to it.

Hospital and county plans were discussed and it was reported to the committee that eight new Emergency Hospitals had been approved for Kentucky.

School Health Committee

R. E. Davis, M.D., Central City, Chairman

Lexington **January 9, 1964**

The School Health Committee, at its first meeting of the year, voted to recommend to the KSMA Board of Trustees that an Association of Team Physicians on the Medical Aspects of Sports be organized within KSMA and under the sponsorship of this committee.

It was also announced that the committee would present a symposium on Athletic Injury Prevention at the 1964 KSMA Annual Meeting and that Thomas Shaffer, M.D., Columbus, Ohio, would appear on this program.

The committee voted to meet again on Thursday, April 2, 1964.

McDowell Home Committee

Laman A. Gray, M.D., Louisville, Chairman

Lexington **January 18, 1964**

The KSMA McDowell Home Committee, at a recent special meeting, was presented with two gifts for the Ephraim McDowell Home. Laman A. Gray, M.D., Louisville, chairman of the McDowell Home Committee, accepted the gifts on behalf of the Kentucky State Medical Association.

The Ephraim McDowell Library, consisting of 27 medical books published in the 18th century and donated by a physician in Baltimore, Maryland, was one of the valuable additions for the McDowell Home.

Also presented to the Association was an early 19th century wedgwood pill tile, cutting machine, and pill rounder. The chairman accepted these gifts from Walter Bett, M.D., representing Charles Pfizer & Company.

Members of the committee voted to investigate the cost of installing a kitchenette and powder room in the McDowell Home. It was also reported that the Home would have to be painted this year.

The committee will meet again in Danville on April 18.

KSMA Adds Five New Members

The Kentucky State Medical Association has added the names of five physicians to its membership rolls as of February 10.

Max Ervin, M.D., Nina Kateryniuk, M.D., George M. Lawson, M.D., and Jesse F. Minnis, Jr., M.D., are new KSMA members from Louisville. Aaron S. Mason, M.D., of the Lexington Veteran's Administration Hospital, has become an associate member.

Dr. Fadell to Head Pathologists

Edward J. Fadell, M.D., Louisville, was named president elect of the Kentucky Society of Pathologists at the December 7 meeting of the group at the Brown Suburban Hotel in Louisville. James E. Parker, M.D., Louisville, who was installed at the December 7 meeting, took office January 25. Secretary-treasurer for 1964 will be John D. Allen, M.D., Louisville.

Keeneys are Citizens Laureate

Arthur H. Keeney, M.D., and Virginia T. Keeney, M.D., Louisville husband-and-wife physicians, were presented the Citizen Laureate award by the Louisville Younger Woman's Club at the club's Charity Ball on February 1 at Freedom Hall. Doctor Arthur Keeney was recognized for his work in highway safety. He is chairman of the KSMA Highway Safety Committee. Doctor Virginia Keeney was cited for her volunteer work in the Sabin Oral Sunday programs.

IN THE BOOKS

HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES: by Adolph G. DeSanctis, M.D., and Charles Varga, M.D.; Third Edition; Published by The C. V. Mosby Co., St. Louis, Mo., 1963; 457 pages; Price, $12.75.

The authors have incorporated in their 457-page book a great deal of valuable, usable and easily found medical information that can be applied to the medical care of pediatric emergencies. The book is written in a way that emphasizes the differential diagnosis of emergency conditions and situations. It is divided into sixteen separate chapters, each one dealing with a different phase of medical and surgical management.

The chapter on cardiovascular emergencies differentiates quite well the causes for heart failure and arrhythmias, and clearly describes the approach to proper medical management.

Fluid therapy is covered in detail, with emphasis on the etiology of various acid base imbalances. Unfortunately, these authors have not seen fit to simplify fluid therapy in the same manner as has been done with most of the other medical treatment regimes.

An excellent discussion involving congenital, developmental and infectious renal emergencies is outlined.

The section on central nervous system emergencies differentiates very well between acute and chronic problems, and a systematic approach to the diagnosis and treatment of diseases ranging from subdurals to meningitis is covered adequately.

The chapters on respiratory emergencies and problems of the newborn are written in a simplified manner so that even a junior medical student should be helped in differential diagnosis after reading this material.

The chapters covering pediatric anesthesia and the emergency treatment of shock and hemorrhage, although brief in nature, tend to summarize valuable and readily available material.

Treatment of chemical agent injuries and the correct emergency approach to handling eye injuries are outlined adequately.

An excellent chapter discusses emergencies due to hypersensitivity and animal bites with ready references not only to differential diagnosis but to treatment and to availability of serums for specific treatment.

The best-written chapter discusses in detail pediatric procedures and is well illustrated. Directions for doing spinal taps, bone marrows and giving and taking blood from a child are beautifully written.

The final chapter is an excellent reference to the diagnosis and treatment of many types of poisons.

This book has an appendix and many valuable tables of both drug dosages and body chemistry normal values. I believe that this textbook would be a handy source of reference material for anyone treating children.

Richard S. Wolf, M.D.

RESULTS OF SURGERY FOR PEPTIC ULCER: A cooperative study of 12 Veterans Administration Hospitals edited by R. W. Postlethwait, M.D., and James C. Thoroughman, M.D.; Published by the W. B. Saunders Co., Philadelphia, 1963; 308 pages; Price, $8.00.

This is an attractive little volume and deals, with economy of space, with some very important and controversial aspects of peptic ulcer. It is collaborated in by 16 surgeons from 12 Veterans Administration Hospitals. It is a retrospective study with collection of patient records and 2977 operative reports beginning in 1947 and extending for at least ten years with followup on results from two to five years.

The large accumulation of data and statistics, checked by biostaticians, is presented in 14 chapters. These include the four complications of peptic ulcer (perforation, hemorrhage, obstruction, intractability) as well as topics such as results of various types of operations, late gastrointestinal syndromes, etc.

Statistics and tabulations dominate the work and these are compared with the larger, more important series and reports in the literature. A closely similar format is followed in each chapter; reading is easy and figures readily available.

A number of the known trends such as the high lethality of the first hemorrhage and the adverse effect of age and debilitating disease on the bleeding ulcer patient are well demonstrated, and an occasional unsuspected finding is brought out. Thus, the relatively low ulcer recurrence following vagotomy and emptying procedure (6.8%) compared to subtotal gastrectomy for gastric ulcer (9.1%) and for duodenal ulcer (11.4%) were a surprise to the reviewer.

One unavoidable shortcoming of the book lies in the fact that the overwhelming majority of patients are males and have a certain V. A. similarity or homogeneity. However, correlations within the group are valid and results are comparable with the literature.

Another shortcoming is that during the period of this study, operative emphasis was chiefly upon gastrectomy. Thus, although the literature is reveiwed on the subjects, there is relatively small experience with definitive surgery for perforated ulcer, still less with vagotomy, pyloroplasty and suture for bleeding ulcer, and nothing upon gastric cooling for bleeding ulcer.

In summary, the book is a very readable reference, based upon a tremendous personal experience and contains in addition a wide up-to-date review of the literature and an excellent bibliography.

Joseph E. Hamilton, M.D.

In Memoriam

JOHN P. WYLES, M.D.
Cynthiana, Ky.
1881-1964

John P. Wyles, M.D., 82, retired Harrison County general practitioner, died January 20 at Cynthiana after a long illness. Doctor Wyles, who retired in 1962, graduated in 1910 from the Medical Department of the University of Louisville. He was a member of the Harrison County Medical Society and was on the Board of Directors of the Harrison Memorial Hospital. A veteran of World War I and an active participant in local civic, church, and social organizations, Doctor Wyles had practiced in Cynthiana and Harrison County for 51 years.

JAMES A. RYAN, M.D.
Covington, Ky.
1886-1964

James A. Ryan, M.D., retired Covington surgeon, died January 18 after more than 50 years of medical practice in the Northern Kentucky area. A 1909 graduate of the Miami Medical College in Cincinnati, Doctor Ryan was the first physician to intern at St. Elizabeth Hospital in Covington. Following postgraduate work at Cornell University and the University of Vienna, he began his practice in Covington in 1912. A past president of the Campbell-Kenton County Medical Society and of the Southern Medical Association, Doctor Ryan was active in community affairs.

BEVERLY S. BROADDUS, M.D.
Irvine, Ky.
1878-1964

Beverly S. Broaddus, M.D., 85, died at his home in Irvine on January 16. A retired general practitioner and an emeritus member of the Kentucky State Medical Association, Doctor Broaddus graduated from the Hospital College of Medicine in Louisville in 1905. Until his retirement several years ago, he had practiced medicine in Estill County for more than 50 years. He was a former member of the Irvine School Board and took part in many other community activities.

MARSHALL M. COLLINS, M.D.
Lackey, Ky.
1871-1964

M. M. Collins, M.D., 92, Lackey, died January 24 at the Beaver Valley Hospital in Martin. The former Chesapeake and Ohio Railway surgeon graduated in 1897 from the Kentucky School of Medicine in Louisville. An emeritus member of the Kentucky State Medical Association, Doctor Collins was a member of the Floyd County Hall of Fame and a 33rd degree Shriner. He retired from active practice in 1955.

CHARLES K. BECK, M.D.
Louisville, Ky.
1884-1964

Charles Kirtley Beck, M.D., Louisville, who limited his practice to otolaryngology-opthalmology, died January 25 at Kentucky Baptist Hospital at the age of 79. A 1908 graduate of the Medical Department of the University of Louisville, Doctor Beck was a former member of the faculty of the U. of L. School of Dentistry and a veteran of World War I. An emeritus member of KSMA, he was a member of several other medical organizations and was active in church and civic work.

Freedman Lectures Set for April

Bernard S. Wolf, M.D., chairman of the department of Radiology at Mount Sinai Hospital and associate clinical professor of radiology at Columbia University in New York City, will present the University of Cincinnati Medical Center's 16th annual Freedman Lectures on April 4 and 5. The lectures are free of charge.

Case Discussion

(Continued From Page 215)

more extensive procedures, such as gastric resection.

Severe stenosis of the lower esophagus with esophagitis constitutes the most serious problem to the surgeon. Elimination of the strictured area of the esophagus usually results in further incompetence of the cardioesophageal junction. Extensive procedures to keep the gastric secretions from the lower esophagus are thus usually required in addition to removal of the strictured esophagus. It would therefore save the patient much distress if he could be treated before this serious complication occurs.

W. B. SAUNDERS COMPANY features the following new books and new editions in their full page advertisement appearing elsewhere in this issue:

AVERY—THE LUNG AND ITS DISORDERS IN NEWBORN INFANTS

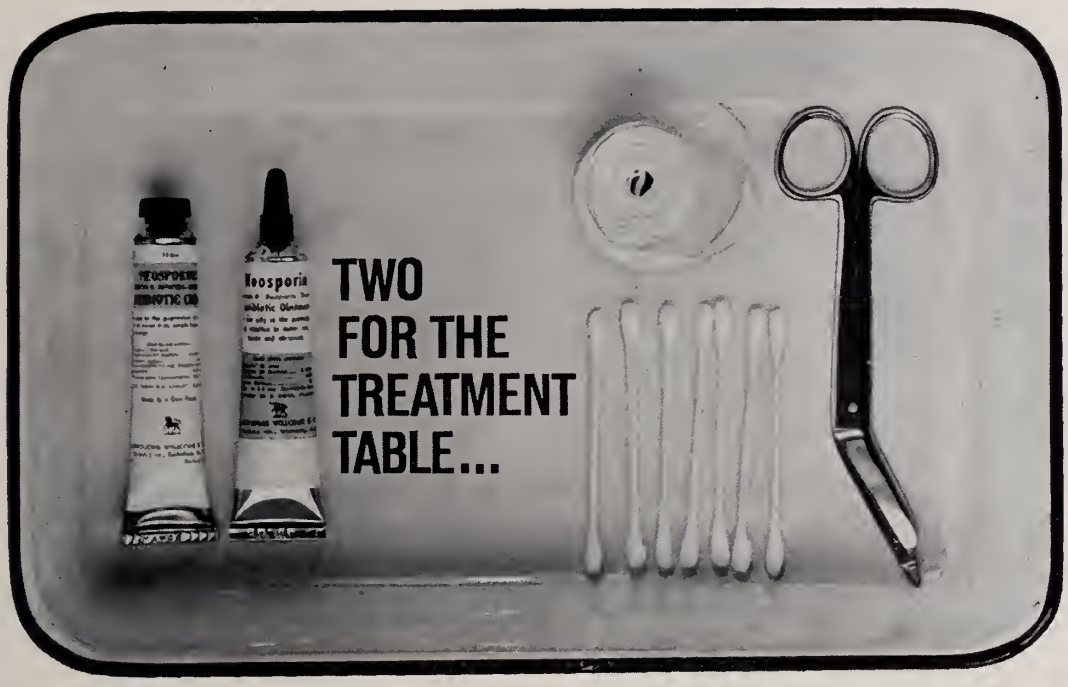
New! The first of a projected series of monographs on individual topics in Pediatrics. Covers all aspects of each subject.

CECIL-CONN—THE SPECIALTIES IN GENERAL PRACTICE

New (3rd) Edition!—The general practitioner's guide to those special conditions he can handle himself.

STODDARD—CASE STUDIES IN OBSTETRICS AND GYNECOLOGY

New!—Sixty case problems give you a wealth of medical information. A veritable treasure-trove of practical, clinical advice.



Both the Cream and Ointment rarely sensitize and are bactericidal to virtually all gram-positive and gram-negative organisms found topically, including Pseudomonas aeruginosa and Staphylococcus aureus.

Indications: Wherever infection occurs and is accessible for topical therapy.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

'NEOSPORIN'® brand
POLYMYXIN B / NEOMYCIN / GRAMICIDIN
ANTIBIOTIC CREAM

Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Gramicidin 0.25 mg.

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, distilled water, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax and 0.25% methylparaben as preservative.

*U.S. Patent Nos. 2,565,057-2,695,261

Available: In 15 Gm. tubes.

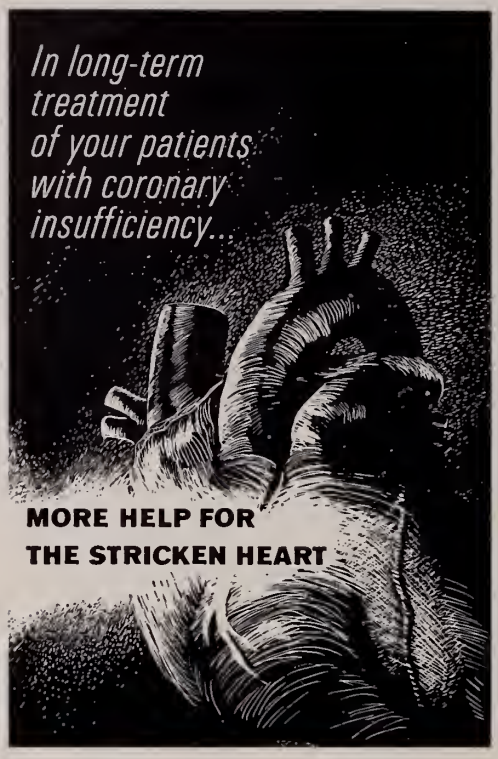
'NEOSPORIN'® brand
POLYMYXIN B / BACITRACIN / NEOMYCIN
ANTIBIOTIC OINTMENT

Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base).

Available: Tubes of 1 oz., ½ oz. and ⅛ oz.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.



■ PETN (pentaerythritol tetranitrate) to increase oxygen supply

■ plus meprobamate to decrease anxiety and tension

Unlike phenobarbital, meprobamate is *not* cumulative and does *not* cause depression.

Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Precautions: Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Contraindications: Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* Dosage: 1 to 2 tablets, *before meals* and at bedtime. Individualization required. Supplied: Bottles of 50 tablets.

CML-1055

MILTRATE®

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

Ky. Dietetic Assn. To Meet

Philip White, M.D., Director of the department of Foods and Nutrition of the American Medical Association, will moderate a panel on "New Trends in Obesity Research" at the spring convention of the Kentucky Dietetic Association in Louisville April 2 and 3.

Other participants on the program will be Robert S. Tillett, M.D., Louisville, chairman of the KSMA Diabetes Committee, who will speak on "Metabolic Aspects of Obesity", and Franklin B. Moosnick, M.D., Lexington, whose topic is to be, "Over-eating—Our American Problem". The meeting will be at the Executive Inn, located off the Watterson Expressway near the Fairgrounds. All KSMA members are invited to attend.

Grayson Hospital Closes

Rising operational costs and the withdrawal of some financial support were cited as reasons for the January 25 closing of the J. Q. Stovall Memorial Hospital at Grayson, Ky.

The 20-bed hospital was founded in 1927 by J. Watts Stovall, M.D., a past president of KSMA, in memory of his father. The late Robert G. Townsend, M.D., was co-owner. In recent years the hospital has operated under the direction of Robert G. Townsend, Jr., M.D., and Paul F. Rizk, M.D.

Peace Corps Seeks Physicians

Peace Corps Volunteer physicians serving in their special fields in challenging projects in Togo and Sierra Leone are testing their skills and ingenuity against diseases and problems seldom encountered in the United States.

Both West African countries are seeking physicians and other health personnel to carry on and expand the work begun by the first groups of medical volunteers soon completing their two-year Peace Corps service. Information and/or applications should be requested from: Physicians, Division of Recruiting, Peace Corps, Washington, D.C., 20525.

Wholesale Drugs

and

Physicians Supplies

JOHN T. VIE CO., INC.

WH 4-7784 New Albany, Ind.

Attention Physicians!

YOU ARE INVITED TO ATTEND

Scientific Session Of The Kentucky Thoracic Society

APRIL 23, 1964

Rankin Amphitheater, Louisville General Hospital

PROGRAM

Morning Session
9 a. m. to 12 noon

"Use of Steroids in the Treatment of Tuberculosis"

Ross McLean, M.D., Emory University, Atlanta, Georgia

"Diagnosis and Treatment of Tuberculosis in Children"

Edith M. Lincoln, M.D., Professor in Pediatrics, New York University School of Medicine; Consultant, Pediatric Service of Bellevue Hospital Center, New York City

"Genito-Urinary Tuberculosis"

Herman Wechsler, M.D., College of Physicians and Surgeons of Columbia University, New York City

Round Table Discussion:

Drs. McLean, Lincoln and Wechsler

Afternoon Session
2 — 5 p. m

"Pathological Changes Due to Chronic Bronchitis and Emphysema"

Jerome Kleinerman, M.D., St. Luke's Hospital, Cleveland, Ohio

"Physiological Changes Due to Chronic Bronchitis and Emphysema"

Ben Burrows, M.D., University of Chicago, Chicago, Illinois

"Clinical Recognition and Treatment of Reversable Factors in Bronchitis and Emphysema"

Ross McLean, M.D., Emory University, Atlanta, Georgia

Round Table Discussion:

Drs. Kleinerman, Burrows and McLean

Dr. Wilson Heads Eye Clinic

Charles F. Wilson, M.D., Pikeville ophthalmalogist, and Mrs. Wilson returned February 24 from Haiti, where they spent two weeks conducting free clinics under the auspices of the Foreign Ophthalmologists from the United States, an organization sponsored by the University of Illinois and Loyola University.

Doctor Wilson, who was one of the nine charter members of FOCUS, had a leading role in a documentary movie made by the University of Illinois during this year's tour. The Wilsons also conducted the clinics for the underpriviledged in Haiti last year. All members of the FOCUS group give their services for nothing, in addition to paying their own personal transportation costs and expenses.

Lipid Disorders Under Study

A research program concerning lipid disorders of children is being initiated by St. Jude Hospital, Memphis, Tenn. A limited number of children with specified problems will be accepted for study and care as outpatients or inpatients. Interested physicians should contact Paulus Zee, M.D., by phone at Area Code 901, 525-8381, or by mail at St. Jude Hospital, 332 N. Lauderdale, P.O. Box 318, Memphis, Tenn. 38101.

Virginia Ophthalmology Program

The 37th Annual Spring Congress in Ophthalmology will be held April 6-9 at Gill Memorial Eye, Ear and Throat Hospital in Roanoke, Va. The program will feature a number of authorities in ophthalmology from all parts of the United States. Registration is limited. A fee of $75 will be charged. Those interested contact the Elbyrne G. Gill Eye and Ear Foundation, Inc., 711 S. Jefferson St., Roanoke.

Our Advertisers

Are Carefully Selected

They Deserve Your Consideration

Hospitals Use Carte Blanche

A number of Kentucky hospitals are among the more than 1200 hospitals in 50 states participating in the guarantee of in-patient accounts program sponsored by a major credit card company. The Hilton Credit Corporation's cards, Carte Blanche, provide credit privileges on a world-wide basis. Membership in the American Hospital Association is not required for participation in the program by a hospital.

W. Va. Academy to Meet

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its 17th annual meeting at the Greenbrier Hotel at White Sulphur Springs on April 15-18. A registration fee of $35 for associate members will cover all social and scientific sessions. For additional information, contact Worthy W. McKinney, M.D., Professional Park, Beckley, W. Va.

Nearly $175,000,000 has been paid through Blue Cross

Plans for care of servicemen's dependents under the Dependents Medical Care Program, it was announced by Antone G. Singsen, vice president of the Blue Cross Association, Chicago, in a year-end review. The amount covered hospital care and services of private duty nurses during the seven years of this program's operation, through the end of 1963. "The Blue Cross Association is, and always has been, the largest private contractor involved in the Medicare program", Mr. Singsen stated.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

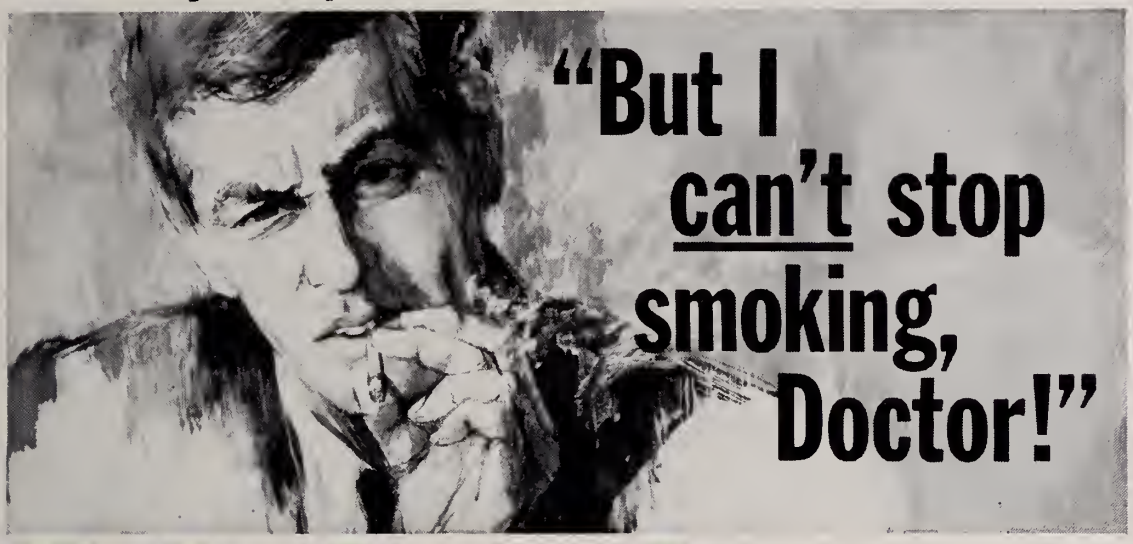
You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

When your patient says:



Nikoban® PASTILLES

BRAND OF LOBELINE SULFATE, MRT

help curb the smoking habit

- Help induce a feeling of satiety similar to that of tobacco because of lobeline's pharmacological relationship to nicotine.
- Permit the patient to indulge his oral fixation by substituting the NIKOBAN Pastille for tobacco.
- Utilize the anorexic effect of lobeline to help the patient who is driven to compulsive eating when he discontinues smoking.
- Encourage patient cooperation through pleasant taste.

Dosage and Administration: In order to obtain the maximum benefit, a NIKOBAN Pastille should be sucked slowly and taken according to the schedule below. Whenever possible a pastille should be taken after meals.

1st week: 1 pastille every 1 to 2 hours for a maximum of 12 pastilles daily. *2nd week:* 1 pastille every 3 hours. *3rd week:* 1 pastille every 4 hours. *4th week:* 1 pastille every 4 to 6 hours. *Thereafter* 1 pastille may be taken at infrequent intervals whenever necessary. In some instances there may at first be a slight astringent burr of the tongue and throat. This will usually disappear as treatment with NIKOBAN Pastilles progresses and is no cause for concern.

Caution: It is advisable neither to smoke nor to use a smoking deterrent during pregnancy.

Formulation: Each NIKOBAN Pastille contains 0.5 mg. lobeline sulfate in a pleasant tasting spiced-cherry base.

Availability: In packages of 50 pastilles.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, Macmillan, 1960, Ed. 2, pp. 620-622; 2. Edmunds, C. W.: J. Pharmacol. and Exper. Therap., 1:27, 1909; 3. Hazard, R. and Savini, E. Gand., 92:471, 1963. 4. Dorsey, J. L.: Ann. Int. Med., 10:628, 1936; 5. Rasmussen, K. B.: Ugeskr.laeger, 118:222, 1956: 6. Ejrup, B.: Sven. lak. Tid., 53:2634, 1956; 7. Jochum, K. and Jost, F.: Munch. med. Wchnschr., 103:618, 1961; 8. Jost, F. and Jochum, K.: Med. Klin., 54:1049, 1959; 9. Smoking and Health, Summary and Report of the Royal College of Physicians of London on Smoking. New York, Pitman, 1962.

M. R. THOMPSON, Inc., Medical Department- BB
711 Fifth Avenue, New York, New York 10022

Gentlemen:
Please send me a trial supply of NIKOBAN Pastilles.

NAME _____ M.D.

ADDRESS _____

CITY _____ ZONE ____ STATE _____

TYPE OF PRACTICE _____

M. R. THOMPSON, INC. • NEW YORK, NEW YORK 10022



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #172. A 35 year old, married, white, gravida 7, para 5, was under the care of a private physician. There was a past history of five normal pregnancies and one abortion at three months. The expected date of delivery as calculated from the menstrual history was May 4, 1962. The patient was Rh positive. She was admitted to the hospital at 8:45 A.M. on May 5, 1962 in early active labor. The blood pressure was 110/90. The fetal heart beat was of good quality. The fetus lay in vertex presentation. At 10:15 A.M. the cervix was dilated to 2 cm. At 12:05 P.M., full cervical dilation was present, but the presenting part remained high. The membranes were intact. The patient was taken to the delivery room at 12:42 A.M. and the membranes were ruptured artificially. Analgesia was then administered in the form of 20% oxygen, 80% nitrous oxide and Trilene. A living male infant weighing 9 pounds, 1 ounce, was delivered at 12:59 P.M. The placenta was expressed intact at 1:02 P.M. Immediately following the delivery of the placenta, heavy bleeding was observed but after the expression of a clot, the uterus became firm and the bleeding diminished. Methergine and Pitocin were administered intramuscularly. An old cervical laceration extending to the pelvic wall was noted on the left side. The cervical margins were approximated by suture, and the bleeding seemed to be controlled. The fundus remained firm. At 1:35 P.M., the blood pressure was 100/50, the pulse 68, and the respirations, 18. Blood loss was estimated at 250 cc. The patient's condition on leaving the delivery room was described as satisfactory.

At 1:50 P.M., the blood pressure was recorded at 90/60, with the fundus remaining firm. Vaginal bleeding was described as being moderate to heavy. An ampule of Ergotrate was administered intravenously and a clot expressed from the uterus. At 2:15 P.M., the pulse was rapid, and the blood pressure had dropped to 80/50. The patient's physician was called, and 1000 cc of 5% glucose in water with two cubic centimeters of Pitocin added was ordered at 2:30 P.M. At this time the patient's blood was typed and cross-matched with blood bank for transfusion. An obstetric consultant was called. He found the patient in shock and ordered her taken to the operating room, where cutdowns were done for administration of blood under pressure. Sodium benzoate was given intramuscularly at the same time.

It was apparent that an immediate laparatomy was indicated. The anesthetist arrived at 3:24 P.M., and shortly thereafter the abdomen was opened. A large hematoma was encountered on the left side of the pelvis, originating from a laceration on the left side involving one or both uterine vessels. The bleeding vessels were immediately clamped, but despite hemostasis at this point, the patient's condition continued to deteriorate. Cardiac standstill occurred, and failed to rally following the intravenous administration of adrenalin and coramine together with external cardiac massage and ventilation through an endotracheal tube. The patient was pronounced dead at 3:34 P.M. The cause of death was stated to be postpartum hemorrhage secondary to a uterine laceration.

Comments

This case represents two common deficiencies responsible for maternal death: delay in replacement blood transfusion, and unavailability of prompt consultation. Lacerations of the uterus above the cervix usually require immediate removal of the uterus, even if this entails immediate preoperative transfusion with group-specific blood that has not been cross-matched. The danger of delay is death, and it obviously outweighs the alternate danger of possible renal failure. Uterine rupture is not often anticipated following a previous cesarean section or myomectomy according to maternal mortality statistics this serious accident most commonly occurs spontaneously as the case in question. Antecedent history of injudicious use of oxytocics during labor a much indicted procedure is also lacking in many cases. Transverse lie or other abnormal presentation is frequently associated with rupture. The present case, that of apparently normal multipara with a cephalic presentation presented clearcut evidence of

severe cephalopelvic disproportion in the form of failure of descent of the presenting part in the presence of progressive cervical dilation. The patient's multiparity should not cause the physician to ignore completely the possibility of great disproportion, with resultant neglected obstructed labor. Hemorrhage from a ruptured uterus may remain externally invisible as long as the head occludes the torn vessels. Such bleeding may first become evident after delivery. Patients with this lesion may be examined for cervical lacerations alone as in the present case, and lifesaving procedures for hemostasis may be delayed to the point of fatal exsanguination. Preventable factors on the part of the physician appear from this protocol to have played the most significant role in the patient's death.

Proctologists Release Program

The world's greatest authorities on proctologic diseases will gather in Philadelphia for the meeting of the American Proctologic Society and the Section of Proctology of the Royal Society of Medicine to be held at the Bellevue Stratford Hotel May 9-14. Program Committee chairman is Harry E. Bacon, M.D., 255 South 17th Street, Philadelphia, Pa. 19103.

I.U. Medical School Dean Dies

John D. VanNuys, M.D., 56, dean of the Indiana University School of Medicine in Indianapolis for nearly 17 years, died unexpectedly in his sleep at home early on the morning of February 15. Death was believed due to a heart attack.

The distribution of free cigarettes and other tobacco products in the Veterans Administration's 168 hospitals and 18 domiciliaries was discontinued on the order issued February 5 by the VA. The action followed the intensive study and evaluation of the "smoking and health" report of the Advisory Committee to the U.S. Surgeon General.

WANTED

Full-time industrial physician for large plant of the Du Pont Company in Parkersburg, West Virginia—a growing industial area on the Ohio River. Salary Open. Permanent employment. Excellent opportunity. Please contact H. F. Gilbert, M. D., E. L. DuPont de Nemours & Company, P. O. Box 1217, Parkersburg, West Virginia. An Equal Opportunity Employer.

World Medical Program Planned

Urho K. Kekkonen, the president of Finland, has accepted an invitation to address the opening session of the 18th Assembly of the World Medical Association in Helsinki, Finland on June 13-19, according to Austin Smith, M.D., Washington, chairman of the U.S. Committee of the WMA. At the same session Professor Urpo Siirala of Finland will be installed as president of the WMA, succeeding Edward R. Annis, M.D., of Miami, Fla., who is also current president of the AMA.

Oral Surgeons to Give Award

A cash award for oral surgery research papers will be given at the 46th Annual Meeting of the American Society of Oral Surgeons in Las Vegas November 3-7, 1964. The award will go to superior, original, unpublished manuscripts concerning research completed during the current year. For information write to: American Society of Oral. Surgeons. 919 North Michigan Avenue, Chicago 11, Ill.

Closed-circuit color television will be a feature of the 1964 American Industrial Health Conference in Pittsburg, Pa., April 13-16. The conference encompasses the annual meetings of the Industrial Medical Association and the American Association of Industrial Nurses. For information contact the Industrial Medical Association. 55 East Washington St., Chicago, Ill., 60602.

MURFREESBORO - VACANCIES:

STAFF PHYSICIANS for 1275 bed neuropsychiatric hospital, including 350 general medical and geriatric. Modern facilities for diagnosis and treatment of mental illness. Salary $11,150 to $18,405 depending on qualifications; fringe benefits; cost of moving to Murfreesboro will be paid by Veterans Administration; visit here for evaluation can be arranged at our expense. Excellent educational opportunities for students in this area. Contact Director, Veterans Administration Hospital, Murfreesboro, Tenn.



Baker's B

VOL. 1 NO. 1 FORECAST: HAPPY MOTHERS AND BABIES

NEW 'UNDERC SOLVES DIAPE

Trio of suspects identified...

Bacteria a Prime Culprit Organisms such as Bacillus ammoniagenes and Alcaligenes faecalis metabolize urine into chemical irritants. Proper laundering of diapers helps reduce number of organisms, but cannot completely eliminate bacterial growth.

Ammonia and Urea Implicated Ammonia produced by microorganisms is a major cause of skin irritation that leads to diaper rash.

The Moisture—Maceration—Infection Cycle Moisture from urine and feces, combined with diaper friction, results in damp, macerated skin—an ideal environment for bacterial proliferation. In the absence of energetic countermeasures, the moisture—maceration—infection cycle continues, leads to chronic diaper rash problems.



aby News



BAKER LABORATORIES, INC.

OVER' AGENT
R RASH CASE!

Diapersil successful!

Bactericidal to Ammonia-Splitting Pathogens Diapersil contains benzalkonium chloride, which is rapidly 'cidal' to organisms implicated in diaper rash. Benzalkonium chloride has a proven record of effectiveness and safety.

Continued 'Uripellent' Protection Silicones in Diapersil form a water-resistant coating which shields the skin from bacterial by-products and from maceration. Silicones have been found outstandingly effective in diaper rash, even when other types of therapy have failed.

Soothing to Inflamed Skin Panthenol, incorporated in a soothing and non-sensitizing base, relieves itching and pain, and gently promotes healing. Diapersil thus provides prompt symptomatic relief in diaper rash as well as in other pediatric skin conditions.

BAKER'S DIAPERSIL™ CREME

Formula: panthenol, dimethylpolysiloxane, benzalkonium chloride, in a watermiscible, non-sensitizing cream base

To treat and prevent diaper rash, excoriated buttocks, chafing, heat rash and similar conditions

BAKER LABORATORIES, INC. Subsidiary of U.S. Vitamin & Pharmaceutical Corp.

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS — 1963-1964

GEORGE P. ARCHER, Prestonsburg ..... President
DELMAS M. CLARDY, Hopkinsville ..... President-Elect
DAVID M. COX, Louisville ..... Immediate Past President
CARLISLE MORSE, Louisville ..... Vice President (Central)
CARL C. COOPER, Bedford ..... Vice President (Eastern)
JOHN DICKINSON, Glasgow ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, Corbin ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
DOUGLAS E. SCOTT, Lexington ..... Chairman of the Board of Trustees
GABE A. PAYNE, JR., Hopkinsville ..... Vice Chairman of the Board of Trustees

DELEGATES TO THE A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

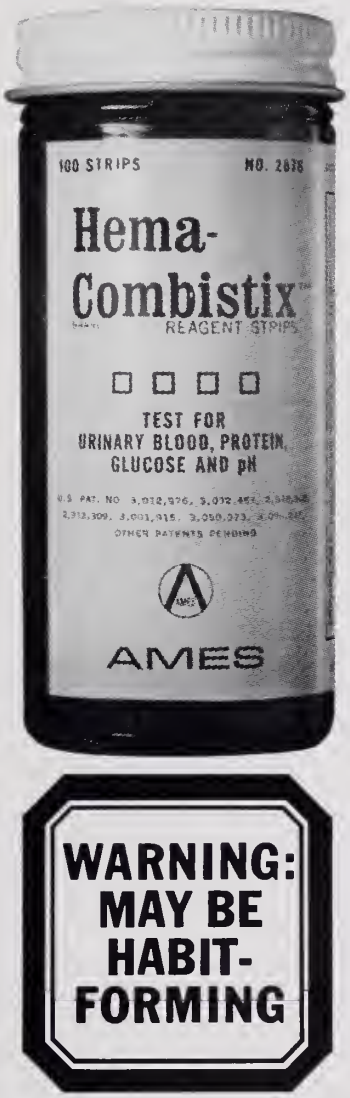
BOARD OF TRUSTEES

First District ..... O. LEON HIGDON, Katterjohn Building, Paducah 1965
Second District ..... HOWELL J. DAVIS, 330½ Allen Street, Owensboro 1964
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville (serving interim term) 1964
Eighth District ..... DON JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1964
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1964
Eleventh District ..... HUBERT JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... CLYDE C. SPARKS, Mayo Arcade, Ashland 1964
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

BUYERS GUIDE

JOURNAL OF KENTUCKY STATE MEDICAL ASSOCIATION, MARCH, 1964

Ames Company 2S7
Baker Laboratories 2S4-2S5
Blue Cross Hospital Plan 23S
Burroughs Wellcome 186-247
Chatham Pharmaceuticals, Inc. 239
Coca-Cola Company 240
Du Pont De Nemours & Company 2S3
Endo Laboratories 187
First Texas Pharmaceuticals, Inc. 241
Geigy Pharmaceuticals 190
The Keeley Institute 2S0
Kentucky T. B. Association 249
Lederle Laboratories 193-231
Eli Lilly & Company 194
J. O. Mattox, M.D. 239
Medical Protective Company 240
New Castle Sanitarium 228
Emerson A. North Hospital 191
Parke, Davis & Company 180
A. H. Robins Company 189-229
Roche Laboratories 2S8
G. D. Searle & Company 221
Smith Kline & French 233
Southern Optical Company 228
E. R. Squibb & Sons 181
M. R. Thompson, Inc. 2S1
Upjohn Company 242-243
Veterans Administration 2S3
John T. Vie Company 248
Wallace Laboratories 18S-22S-248
Winthrop Laboratories 183



Once you have used **HEMA-COMBISTIX,**™ dip-and-read test for urinary blood, protein, glucose, and pH, it may become a habit to test every patient's urine routinely with this simple, convenient reagent strip. Most of the answers will be "negatives," but an unexpected "positive" may alert you to serious pathology even before related symptoms appear. The test takes only 60 seconds. As basic as the stethoscope...**HEMA-COMBISTIX** is a *good* habit to form. □ Ames Company, Inc., Elkhart, Indiana. 68764

AMES

anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety reduced to its proper perspective

LIBRIUM®
(chlordiazepoxide HCl)
the successor
to the tranquilizers

ROCHE

In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment. Caution should be exercised in prescribing any therapeutic agent for pregnant patients. Supplied—Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.

APRIL 1964 • VOLUME 62 • NUMBER 4

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



In This Issue

Snakebite Accidents in Kentucky
Henry M. Parrish, M.D., and Louis P. Donovan, M.S. 275

Four Lesser Veneral Diseases
William E. McDaniel, M.D. 281

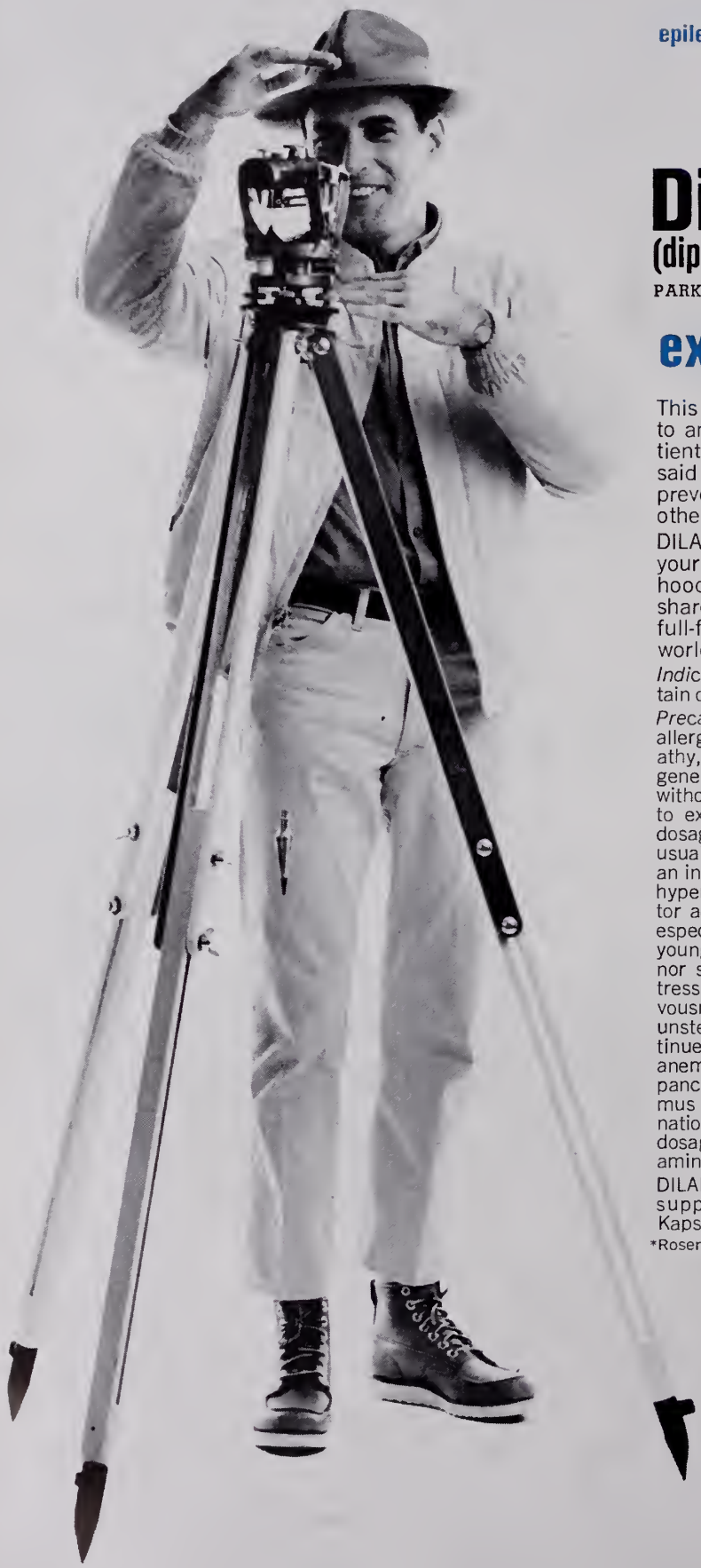
What's New in Dermatology
Winston U. Rutledge, M.D. 284

Education and Training For Community Psychiatry
Bernard C. Holland, M.D., and Robert A. Porter 286

Mass Glaucoma Screening in Kentucky
James L. Stambaugh, M.D 289

Complete Contents on Page 262

KSMA Interim Meeting April 23
Jenny Wiley State Park, Prestonsburg, Ky.



epilepsy may limit opportunity...



Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

extends horizons

This agent "...has brought new hope to an entire generation of seizure patients....With judicious use, it may be said that it alone is responsible for the prevention of more seizures than any other drug."*

DILANTIN (diphenylhydantoin) can help your epileptic patient to earn a livelihood...to prove his worth...and to share in the daily give-and-take as a full-fledged member of the workaday world.

Indications: Grand mal epilepsy and certain other convulsive states.

Precautions: Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia, aplastic anemia, leukopenia, granulocytopenia and pancytopenia have been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

DILANTIN (diphenylhydantoin sodium) is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm.

*Roseman, E.: *Neurology* **11**:912, 1961. 33664

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

For that extra bit of knowledge which may offer you the key to a puzzling diagnostic or therapeutic problem . . .

SAUNDERS PRACTICAL "SPECIALIZED" VOLUMES

NEW! Avery — The Lung and its Disorders in Newborn Infants

This is Volume I of a new monograph series, "Major Problems in Clinical Pediatries." Each volume will take a significant problem facing pediatricians today and exhaustively delineate current knowledge about the disorder and how it may best be managed. Other volumes scheduled in addition to the one below will cover Jaundice, Severe Infections, and Hypoglycemias. Consulting Editor of the Series—Alexander J. Schaffer, M.D.

The Lung and its Disorders in Newborn Infants exemplifies the entire series. Dr. Avery first draws a superb picture of the significant anatomic and physiologic aspects of fetal and neonatal respiration. She follows this with clinical, up-to-the-minute assessment of respiratory distress—in disorders ranging from *choanal atresia* to *pulmonary hemorrhage*. You'll find a wealth of practical, well-illustrated advice on *management of hyaline membrane disease, on differential diagnosis of the various respiratory abnormalities, on resuscitation of the asphyxiated newborn, on data showing normal lung volumes in infants, and on recognition of both normal and abnormal chest films*. Here is a complete, definitive picture in one single source.

By MARY ELLEN AVERY, A.B., M.D., Assistant Professor of Pediatrics, Johns Hopkins School of Medicine; Pediatrician-in-charge, Newborn Nurseries, Johns Hopkins Hospital. About 225 pages, 6⅛" x 9¼", illustrated. About $7.50.

New—Just Ready!

NEW (3rd) EDITION! Cecil-Conn — The Specialties in General Practice

In this *New (3rd) Edition* outstanding specialists pinpoint important clues to diagnosis and effective treatment for those diseases and conditions of a specialized nature that are often encountered by the non-specialist. You'll find precise, specific information to help you in successful management of patients with diseases of the *bladder and kidney; anorectal diseases; ophthalmologic disorders; neuroses and psychoses; etc.* For each disorder you'll find information on normal anatomy, physiology, differential diagnosis, treatment, complications, pathologic physiology, dietary regimens, therapeutic schedules, etc. Danger points are carefully pointed out—those symptoms and findings which demand immediate referral for special management. For this *New (3rd) Edition* there are new contributors for the sections on *Surgery, Orthopedic Trauma; Gynecology and Obstetrics; Nose and Throat; Larynx, Bronchi and Esophagus; and Otology*. In addition, entirely new chapters give you extra help on using the clinical laboratory more effectively, and on problems met by the general practitioner in industrial medicine.

By 15 Outstanding Specialists. Edited by RUSSELL L. CECIL, M.D., Professor of Clinical Medicine, Emeritus, Cornell University Medical College; and HOWARD F. CONN, M.D., Editor, Annual *Current Therapy* Volume. About 832 pages, 7" x 10", with about 247 illustrations. About $19.00.

New (3rd) Edition—Ready May!

NEW! Stoddard — Case Studies in Obstetrics and Gynecology

Here is a stimulating new book based on the case-study method of instruction. It will aid you greatly in management of virtually all the important problems encountered in the practice of obstetrics and gynecology. 60 problems are discussed, ranging from *premenstrual tension* to *Rh isoimmunization*. Dr. Stoddard begins each discussion with a typical case history, describing symptoms and signs, results of the physical examination and laboratory tests, type of treatment offered, and long-term results. Next you'll find a thoughtful discussion in which that particular type of disorder is described as to incidence, pathology, prognosis, etc. Then follows a series of provocative questions (the type a consultant would be asked) with sensible answers on pathology, type of treatment prescribed, alternative methods of treatment, effectiveness of therapy, etc. You'll welcome the advice set forth on such vital disorders as: *early abortion; cancer and pregnancy; dysmenorrhea; adrenal virilism; carcinoma in situ of the cervix; toxemia of pregnancy; obstetrical anesthesia accident; etc.* This valuable new book will help you screen important from unimportant aspects of a case, help you avoid a stereotyped approach to management, give you details of unusual cases you may not yet have encountered.

By F. Jackson Stoddard, M.D., Associate Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee, Wisconsin. 312 pages, 6⅛" x 9¼", illustrated. About $10.00.

New—Just Ready!

SJG4-64

W. B. SAUNDERS COMPANY West Washington Square, Phila. 5, Pa.

Please send and bill me:

☐ Avery—*Lung in Newborn*. About $ 7.50
☐ Cecil-Conn—*Specialties*. . About $19.00
☐ Easy Pay Plan ($5 per month)
☐ Stoddard—*Case Studies in Obstetrics & Gynecology*. . About $10.00

Name . . . . . Address . . . . .

VOLUME 62 • April 1964

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR

Sam A. Overstreet, M.D.

• ASSOCIATE EDITOR

Walter S. Coe, M.D.

• MANAGING EDITOR

J. P. Sanford

• ASST. MANAGING EDITOR

Ann M. Huntsman

• DEPARTMENTAL EDITORS

Jack L. Chumley, M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscar J. Hayes, Case Discussions
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR

George F. Brackman, M.D., Chairman
Willett H. Rush, M.D.
Blaine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Maare, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1966

Harold L. Bushey, M.D.
Edward J. Fadell, M.D.
Merle W. Fawler, Jr., M.D.
Joseph L. Goldstein, M.D.
John D. Lovett, M.D.
George F. McAuliffe, M.D.
Ralph G. Thomas, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965

McHenry S. Brewer, M.D.
Lewis Dickinson, M.D.
Zygmunt Gierlach, M.D.
Douglas L. Gillim, M.D.
Arthur H. Keeney, M.D.
James B. Stith, M.D.
Chester B. Theiss, M.D.
Kearns R. Thompson, M.D.

Term Expires July 1, 1964

Herbert L. Clay, Jr., M.D.
Orville T. Evans, M.D.
M. Randolph Gilliam, M.D.
John Gardinier, M.D.
Franklin B. Moosnick, M.D.
William Oldham, M.D.
Howard W. Ripy, M.D.
Samuel M. Smith, Jr., M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205

Subscription $8.00—single copy .80

Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920

JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

Snakebite Accidents in Kentucky
Henry M. Parrish, M.D., and P. Donovan, M.S. . . .275

Four Lesser Veneral Diseases
William E. McDaniel, M.D. 281

What's New and What's True of What's New in Dermatology
Winston U. Rutledge, M.D. 284

The Education and Training of Physicians and Psychiatrists For Community Psychiatry
Bernard C. Holland, M.D., and Robert A. Porter . .286

Mass Glaucoma Screening in Kentucky
James L. Stambaugh, M.D. 289

CASE DISCUSSION

Depression Masquerading as Apathy
Hugh A. Storrow, M.D. 292

SPECIAL ARTICLE

Nursing Home Administration Enhanced by Michigan State University
Carrie C. Calvert 294

EDITORIAL

The Thymus—Master Gland of Immunity? 295

ORGANIZATION SECTION

Interim Meeting Plans Complete; Good Attendance Anticipated 298
Ky. M.D.s Urged to Participate in May 3-9 Immunization Week 298
KSMA Trustee District Meetings Scheduled 299
KSMA 1964 Annual Meeting Site is Modern, Convenient, Large 299
KSMA Schedules First Congress on Mental Health for May 14 300
Program, First Kentucky Congress on Mental Health 301
Dr. Scroggin Honored March 6 by Wildlife Federation 304
College of Surgeons Meeting Program Plans Released 302
KAGP Plans Outstanding Program for May 6-8 Annual Meeting 304
Dr. Hester Featured Speaker At Ky. Ob-Gyn Meeting 305
U. of L. Alumni Reunion Set for AMA Annual Meeting 308
Ky. Surgical Society Program to Feature Dr. Warren 308

REGULAR FEATURES

President's Page 264
Public Health Page 266
Postgraduate Page 318
In The Books 324
Insurance Page 329
Maternal Mortality Page 337

disability without debilitation...



supportive oral anabolic therapy • potent • well-tolerated

Disabling illness or injury at any time of life can invite a slowdown in the natural anabolic processes or acceleration of catabolic processes, resulting in a "wasting" of protein and minerals needed for tissue repair. Loss of weight and appetite, strength and vitality, may be the evident signs of this process, frequently accompanied by a lowering of mood, interest and activity. The older the patient, the more pronounced may be the signs of debilitation. A potent, well-tolerated anabolic agent plus a diet high in protein can make a remarkable difference.

WINSTROL® brand of STANOZOLOL

...a new oral anabolic agent, combines high anabolic activity with outstanding tolerance. Although its androgenic influence is extremely low*, women and children should be observed for signs of slight virilization (hirsutism, acne or voice change), and young women may experience milder or shorter menstrual periods. These effects are reversible when dosage is decreased or therapy discontinued. Patients with impaired cardiac or renal function should be observed because of the possibility of sodium and water retention. Liver function tests may reveal an increase in BSP retention, particularly in elderly patients, in which case therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage in adults, *usually 1 tablet t.i.d.;* young women, *1 tablet b.i.d.;* children (school age), *up to 1 tablet t.i.d.;* children (pre-school age), *½ tablet b.i.d. Shows best results when administered with a high protein diet. Available as scored tablets of 2 mg. in bottles of 100.*

*The therapeutic value of anabolic agents depends on the ratio of anabolic potency to androgenic effect. This anabolic–androgenic activity ratio of Winstrol is greater than that of all the oral anabolic agents currently in use.

Winthrop

Winthrop Laboratories, New York, N. Y.



MESSAGE FROM THE PRESIDENT

The Cost of Medical Care

PUBLIC officials, labor leaders, the press, and the private citizen are showing more concern over the rising cost in medical care.

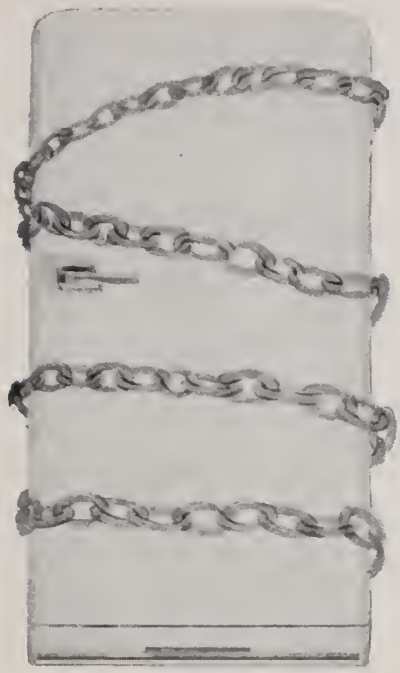
The Consumer Price Index (CPI), published monthly by the U.S. Department of Labor, measures average changes in prices of selected goods and services purchased by wage earners and clerical workers in 46 cities chosen to represent all urban places in the United States (Middlesboro, Kentucky, is one of these 46 cities).

Month after month the CPI has reported the rising cost of medical care. The general term "medical care" as used in the CPI is not broken down as to how the medical dollar is spent. It includes physician fees, dentist fees, drugs, hospital costs, etcetera.

It is easily understandable that some of these costs will increase. Hospital labor, which totals about 70% of all hospital costs, must continue to increase in ratio to other wages in the community. The higher quality of medical care available to the public today demands better training and highly skilled people, and new and better equipment, all of which must add up to increased costs.

Actually the cost of medical care rendered by physicians has not increased in the same proportion as the other goods and services shown in the Index. While we recognize the inevitability of some increases, we as physicians can go a long way toward holding these increases down by controlling utilization of hospitals and prepayment plans. In addition, we can be most effective in our efforts to inform our patients relative to the reason for these increases.

George O. Archer M.D.



an easier way?

'METHEDRINE'® brand METHAMPHETAMINE HYDROCHLORIDE

is an easier way to help control food craving & keep the reducer happy

With "hunger pains" abolished, the patient can shrug off the chains of psychogenic craving that bind him to his habit of overeating and cooperate cheerfully with the prescribed diet.

In obesity, "...our drug of choice has been methedrine (methamphetamine hydrochloride)... because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West. J. Surg. **59**:238 (May) 1951.

Description: Each scored tablet contains 5 mg. 'Methedrine' brand Methamphetamine Hydrochloride.

Dosage: 2.5 mg. (½ tablet) 3 times daily. May be increased gradually according to response; more than 10 mg. daily rarely is needed. The last dose of the day should not be taken later than 6 hours before bedtime.

Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

Supplied: Tablets 5 mg., scored, in bottles of 100 and 1000.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

PUBLIC HEALTH PAGE

Prescription Refills*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health Commonwealth of Kentucky

TODAY'S modern therapeutic drugs are so complex and potent that it is quite evident that proper control and care must be exercised in their use. Before the advent of these therapeutic drugs it was a matter of less consequence whether a patient developed a pattern of continued use or not. Now, however, unlimited use of some medications can result in irreparable harm to the patient. Long term toxicity is not uncommon with many of the new therapeutic drugs. Therefore, controlling the unauthorized refilling of prescriptions is more important today than ever before.

A physician in prescribing medication is expressing his desire for the patient to be treated in a specific manner and it is not only proper but necessary that he be aware at all times of the amounts and type of medication being used by his patient. The Kentucky State Board of Health, aware of the dangers inherent in the indiscriminate use of potent drugs, adopted the following regulation in April of 1962:

> "No pharmacist shall refill a prescription for a drug bearing a 'Federal Caution Legend' unless authorized by the prescribing practitioner. The pharmacist shall record all such refills by writing the date of the refill together with his name or initials on the back of the original prescription. The date of the refill may be stamped on the prescription if the pharmacist so desires."

The majority of drugs prescribed today fall into the "Caution Legend" category and thus are covered by this regulation. This means that an added burden is placed on both the practitioner and the pharmacist to see that only the patient's legitimate medication needs are met. The most practical way to do this is by the practitioner indicating refill instructions on the original prescription either by marking a fixed number of refills or by indicating that no refills are to be made by the pharmacist. These instructions will insure the physician that his patient will receive medication only to the extent of the time desired.

Failure of the practitioner to indicate these instructions on the prescription places the pharmacist in a difficult position when a patient seeks to have a prescription refilled. If this does happen, a pharmacist must do one of two things. He must either turn the patient away or phone the physician for an oral authorization. In many instances it is a time when the physician is with a patient and cannot answer the call or is temporarily unavailable. This being the case the pharmacist may not refill the prescription until he does contact the physician. In the meantime, the patient is often left in a state of confusion and may bear some ill feelings toward health professions in general.

Frequently the patient has been told by his physician to continue on certain medication and when he attempts to have the prescription renewed, finds that the physician has failed to notify the pharmacist and the original prescription does not indicate that it may be refilled. After talking to the patient, such a situation could be avoided if the physician would call the pharmacist instead of waiting to be called.

Many complaints are heard from both the medical and pharmaceutical professions regarding prescription refills. The physician states that in some cases the pharmacist refills prescriptions without authorization and the pharmacist states that the physician objects if he is called too many times for authorization.

Certainly, a much better image of the health professions would be presented to the public if the physician and the pharmacist would work out a suitable arrangement on prescription refills to insure the patient the necessary medication without undue interruption.

**This article was prepared by Robert J. Lichtefeld, M. P. H., Senior Drug Inspector, Food and Drug Program, Kentucky State Department of Health.*

in maintenance therapy...

Arthralgen®

a working analgesic for the active arthritic



ARTHRALGEN®

Each tablet contains:

Salicylamide.....	250 mg.
Acetaminophen....	250 mg.
Ascorbic acid (Vitamin C).....	25 mg.

Arthralgen, a better-tolerated analgesic formulation of time-tested ingredients, works faster to free the arthritic from his pain without salicylate side effects. Since its analgesic components require no chemical conversion to act in the body, Arthralgen's pain relieving benefits are immediately available to provide a smoother, more rapid obtundation of pain than can be achieved with many true salicylates.

Arthralgen is especially useful for the prompt relief of early morning stiffness and pain with less risk of gastric irritation. And since Arthralgen contains no sodium it is safe for long-term use in arthritics who have other conditions which necessitate sodium restriction.

ARTHRALGEN®-PR

Each tablet contains:

Salicylamide.....	250 mg.
Acetaminophen....	250 mg.
Ascorbic acid (Vitamin C).....	25 mg.
Prednisone.....	1 mg.

The basic Arthralgen formulation plus prednisone is indicated for patients who require steroids. Prednisone has three advantages over cortisone, hydrocortisone, and ACTH. They are: (1) lack of sodium retention, (2) absence of increased potassium excretion, and (3) the unlikelihood of steroid-induced hypertension.*

Robins

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms, dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomylitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

A. H. ROBINS CO., INC., RICHMOND, VIRGINIA

In theory, allergy works like this...

It is generally accepted that a complex antigen-antibody reaction underlies allergy. The reaction may be visualized in this simplified graphic form:



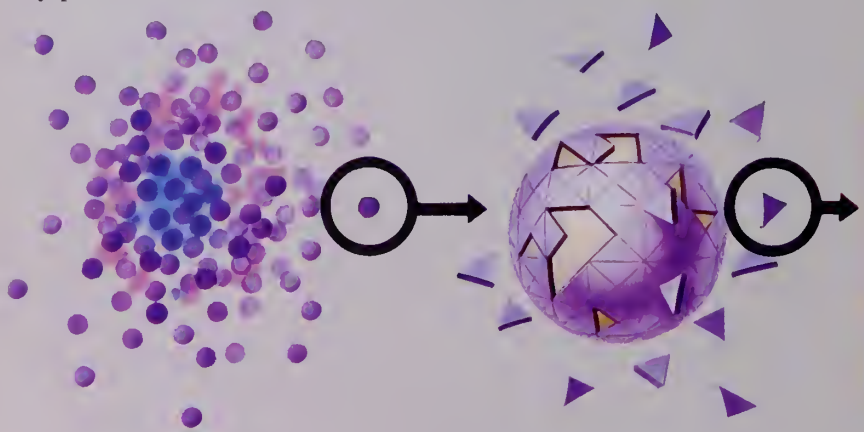
At first exposure to antigens (green) specific antibodies (yellow) are formed chiefly by plasma cells.



Circulating antibodies in the blood stream may become attached to mast cells in the tissues.



If the same *antigen* again enters the body and reacts with *antibodies* attached to cell walls, disturbances occur. The cell disrupts...



...depositing granules containing bound histamine or histamine-like substance in intercellular spaces.

Calcium ions and enzymes act on the granules breaking the binding and releasing histamine or histamine-like substance.



Theoretically, this liberated histamine (purple) acts at *receptor sites* in target tissues resulting in allergic manifestations.



Antihistamine (orange) is believed to compete with histamine at the receptor sites in target tissues — thus counteracting allergic effects.

In allergy, this antihistamine works with no more sedation than placebo*

The therapeutic response to Dimetane (brompheniramine maleate) is eloquent proof that a *potent* antihistamine does not have to be a sedative, too. You may expect unsurpassed relief of symptoms promptly in most types of allergy because Dimetane (brompheniramine maleate) *works* with a very low incidence of side effects. Indeed, as shown in a double-blind crossover study, with no greater incidence of sedation than placebo.*

*Schiller, I. W. and Lowell, F. C.: New England J. Med. *261*:478, 1959.

CONTINUOUS ACTION UP TO 10-12 HOURS

Dimetane® Extentabs®

(brompheniramine maleate, 8mg. & 12mg.)

BRIEF SUMMARY: Indications: Dimetane (brompheniramine maleate) is a potent antihistamine effective in a wide variety of allergic states.

Side Effects: Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia, have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, or giddiness may be encountered. Dryness of the mouth and mydriasis have been reported infrequently.

Precautions: Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

ALSO AVAILABLE: New lower strength Dimetane *8 mg.* Extentabs (brompheniramine maleate 8 mg.); conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

PHARMACEUTICALS · RESEARCH ·

NEW MEN'S SHOP



. . . in our **NEW SOUTHERN**

OPTICAL BUILDING, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

GUILD OPTICIANS

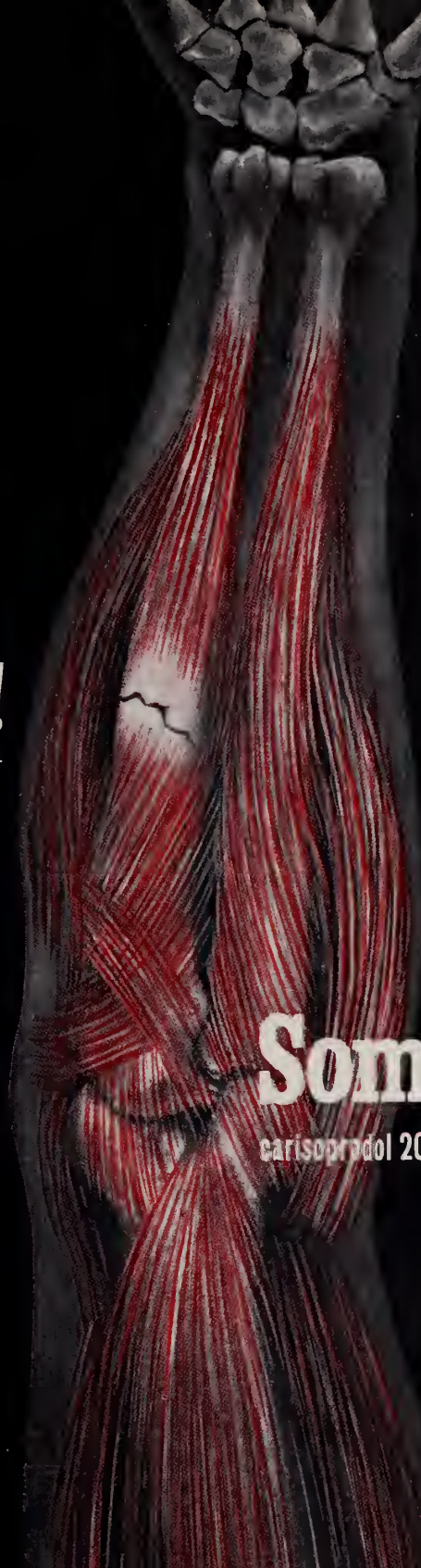
Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®



relieves pain and relaxes muscle

TRAUMA!

Following traumatic injury, patient comfort can be increased and recovery time shortened by the simultaneous treatment of both pain and muscle spasm with 'Soma' Compound.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Also available with ¼ gr. codeine as SOMA® COMPOUND WITH CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit forming).

WALLACE LABORATORIES/*Cranbury, N.J.*

Side effects: Although there has been no evidence of tolerance, withdrawal symptoms or excessive self-medication, 'Soma' Compound and 'Soma' Compound with Codeine, like other central nervous system depressants, should be used with caution in addiction-prone individuals. While codeine addiction is relatively rare and easily broken, the same precautions must be observed as for any other opium alkaloid. Nausea, vomiting, constipation and miosis are possible codeine side effects. Should symptoms of hypersensitivity occur, discontinue medication.

Contraindications: None reported.

Complete product information available in the product package, and to physicians upon request.

Dosage: Usual dosage is 1 or 2 tablets 4 times daily.

Supplied: 'Soma' Compound is available in orange, scored tablets; bottles of 50. 'Soma' Compound with Codeine (narcotic order form required) is available in white, lozenge-shaped tablets; bottles of 50.

CSO-1054

THE ARTHRITICS WHO COULD NOT TAKE STEROIDS

The bane of the steroids, new and old, has been that certain undesirable metabolic effects — including salt and water retention, edema, overstimulation of the appetite, excessive weight gain, mood swings — seemed to be firmly linked to the primary anti-inflammatory action. For arthritics already overweight, or with cardiovascular disease complicated by edema, or those who were tense and anxious, steroid treatment could aggravate their problems. But with the advent of ARISTOCORT® Triamcinolone, many of these arthritics became "steroid-treatable." The reason: Not only did *this* steroid provide gratifying relief of inflammation and pain, but it did so *without* the penalty of overstimulation of the appetite, excessive weight gain, salt and water retention, edema, and undesirable euphoria. Six years of widespread use has confirmed these benefits for other arthritics as well as those formerly untreatable.



Side Effects: Since it may, under some circumstances, produce many of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting. *Contraindications:* While the only absolute contraindications are tuberculosis, herpes simplex and chicken pox, there are some relative contraindications (peptic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

Why not consider ARISTOCORT® Triamcinolone when you are contemplating steroid therapy? Both you and your patient will be gratified with the results.

MAXIMUM STEROID BENEFIT – MINIMUM STEROID PENALTY

Aristocort®

Triamcinolone

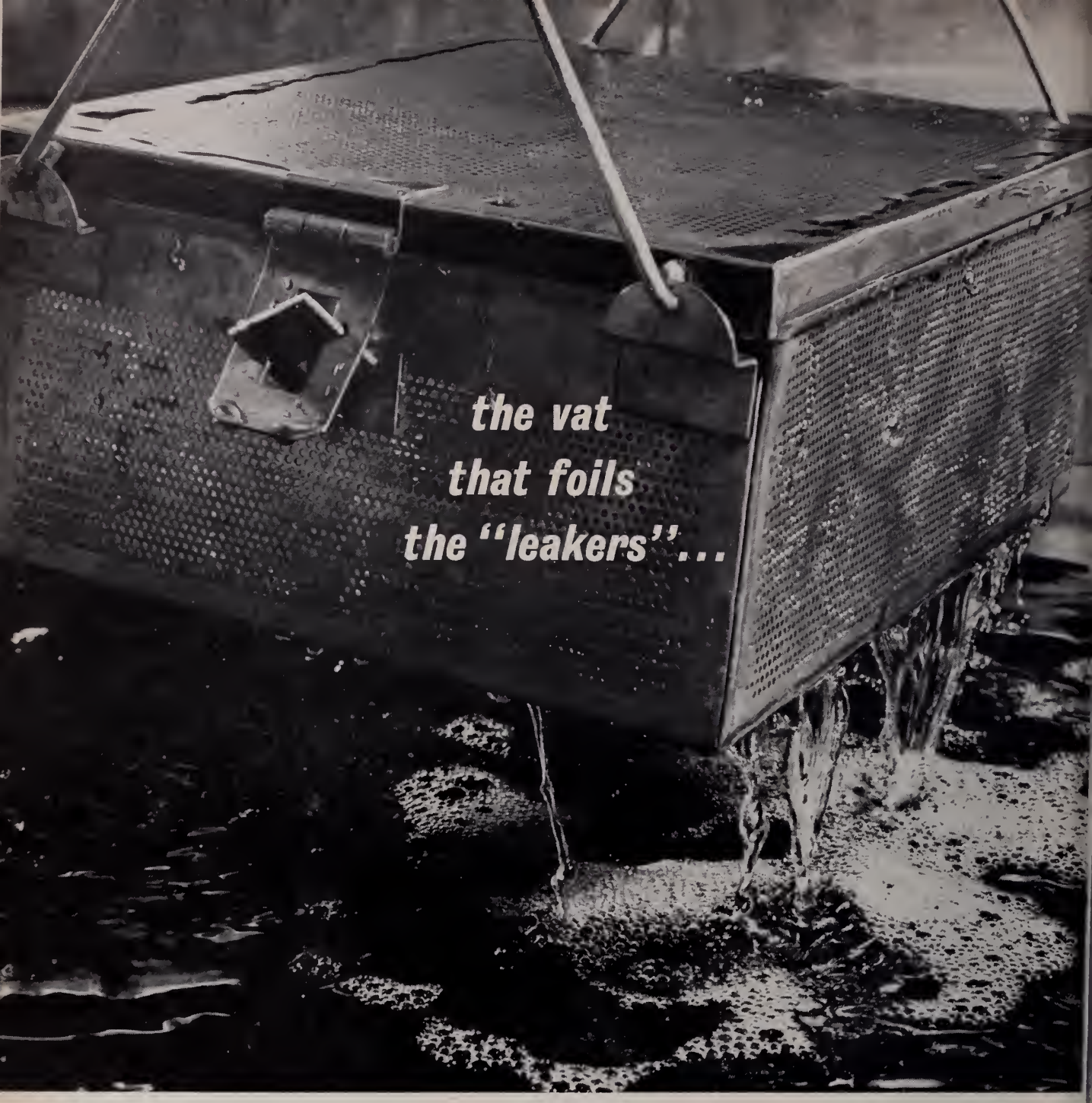
1 mg., 2 mg., 4 mg. or 16 mg. tablets

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

270-4





"Leakers" are ampoules with minute imperfections in the seal. You can't readily see the flaw, and often it's so small that liquids won't even drip through; but microscopic contaminants can slip in to render the contents nonsterile and potentially dangerous. ▪ Detecting "leakers" is the job of the vat and the blue dye. ▪ Sealed Lilly ampoules are placed in baskets, submerged in a vat containing methylene blue, and subjected to a vacuum. If there is an imperfect ampoule in the lot, the liquid is forced out. When the vacuum is released, the blue dye rushes in. ▪ With dye as the spy, elusive "leakers" are quickly spotted and rejected . . . another of the many controls that add immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

400372

The JOURNAL of the
Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE BOARD OF TRUSTEES

VOLUME 62 APRIL, 1964 No. 4

Snakebite Accidents in Kentucky†

HENRY M. PARRISH, M.D.,* DR. P. H., and LOUIS P. DONOVAN, M.S.**
Columbia, Mo.

An estimated 143 (92 in-patients and 51 out-patients) are treated annually in Kentucky for venomous snakebites. The case-fatality rate is less than 0.5%. This paper describes the epidemiology, clinical aspects and treatment of snakebite accidents in Kentucky.

ACCIDENTS resulting from venomous snakebites occur frequently in the East South Central Region (Kentucky, Tennessee, Alabama and Mississippi) of the United States. Accidental injuries produced by various kinds of trauma can be studied by the epidemiological method. There is an epidemiology of venomous snakebites just as there is an epidemiology of tetanus, tuberculosis and trichinosis. Epidemiology assists us in understanding why, where, when, and how snakebite accidents occur in a defined population.

The purpose of this study is to describe the epidemiology of snakebite accidents in Kentucky, to relate some medical findings associated with these bites, and to review briefly current concepts of snakebite treatment.

†*This investigation was supported in part by Public Health Service Research Grant GM11268-02 from the Division of General Medical Sciences, U.S. Public Health Services.*

**Associate professor of Community Health at the University of Missouri School of Medicine, Columbia, Missouri.*

***Research associate in Community Health, University of Missouri School of Medicine, Columbia, Missouri.*



Figure 1. Timber Rattlesnake

Venomous Snakes

According to Conant,[1] the following species and sub-species of venomous snakes are indigenous to Kentucky: the timber rattlesnake *(Crotalus horridus horridus),* the canebrake rattlesnake *(Crotalus horridus atricaudatus),* the northern copperhead *(Agkistrodon contortrix mokeson),* the southern copperhead *(Agkistrodon contortrix contortrix),* and the western cottonmouth moccasin *(Agkistrodon piscivorus leucostoma).*

Timber and canebrake rattlesnakes are related and look very much alike. See Figure 1. They are the most dangerous venomous snakes in Kentucky. The southern copperhead is a paler, pinker relative of the northern copperhead. See Figure 2. Coral snakes are not native to the State.

All of the venomous snakes of medical importance in Kentucky are pit vipers. They are so named because of a characteristic pit which is located between the eye and the nostril on each side of the body. Pit vipers also are identified by elliptical pupils and by two well-developed fangs which protrude from the maxillae when the snake's mouth is opened. Rattlesnakes have rattles which are attached to their tails. Copperheads, cottonmouth moccasins and



Figure 2. Copperhead

harmless snakes do not have rattles. The copperhead has a reddish-brown head and dark, hourglass-shaped crossbands on the body. Harmless snakes do not have facial pits, they have round rather than elliptical pupils, and while they have teeth, they lack fangs.

Methods of Study

A questionnaire and letter explaining the purpose of this study were mailed to a "selected" group of Kentucky hospitals listed in Hospitals (Journal of the American Hospital Association) Guide Issue. The hospitals selected for this study were general hospitals, children's hospitals and college infirmaries. Army, Navy, Coast Guard, Public Health Service, Air Force and Veterans Administration hospitals also were sent questionnaires. Maternity, tuberculosis and mental hospitals were omitted as they would not be expected to treat snakebite victims. A total of 107 Kentucky hospitals comprise the study group. Each hospital was requested to report all in-patients admitted to the hospital for snakebite treatment during 1958 and 1959.

Most hospitals do not code and tabulate the diagnoses of emergency room and out-patient clinic visits. Since some snakebite victims are not admitted to the hospital as in-patients, it seemed essential to ask a sample of practicing physicians how many snakebite victims they treated on both an out-patient (office, home, emergency room, etc.) and on an in-patient basis. Previous surveys,[2, 3] have shown that most people with venomous snakebites are treated by general practitioners, surgeons, internists, pediatricians and orthopedic surgeons. Therefore, a random sample of one-third of all the Kentucky physicians in these categories of practice who were listed in the A.M.A. American Medical Directory were sent questionnaires.

Death certificates for fatal snakebite cases were obtained from the Kentucky State Department of Health.

This report is based on questionnaires returned by 102 (95.3%) of 107 Kentucky hospitals. It is supplemented by questionnaires returned by 259 (68%) of 381 practicing physicians in the state and by one death certificate provided by the Kentucky State Department of Health.

Incidence

Kentucky hospitals reported a total of 123 in-patients treated for venomous snakebites during 1958 and 1959. There were 56 snakebites in 1958 and 67 in 1959, an average of 61 bites per year. The physicians' reports, when adjusted to account for all Kentucky physicians in the practice categories mentioned, indicated that approximately 96 in-patients and 51 out-patients were treated for snakebites each year.

This difference between in-patient reports by hospitals and the estimated in-patients treated by physicians can be accounted for largely by the fact that ten of the less-populated counties from which physicians reported bites do not have hospitals listed in the Guide Issue of Hospitals. However, these counties do have small hospitals and private clinics in which physicians treated 31 in-patients and 30 out-patients for snakebites each year. Physicians in counties from which hospital snakebite case reports were received estimated that 65 in-patients and 21 out-patients were treated per year. The physicians' estimate of 65 in-patients per year for these counties were in close agreement with the 56 to 67 cases per year reported by hospitals.

Taking the afore-mentioned facts into account, we estimate that an average of approximately 143 people (92 in-patients and 51 out-patients) are treated for venomous snakebites every year in Kentucky, an incidence of 4.7 bites per 100,000 people per year.

Geopathology

The geographical distribution of snakebites reported in Kentucky during 1958 and 1959 may be seen in Figure 3. The lightly shaded counties are those from which hospitals reported in-patients treated for snakebites. An

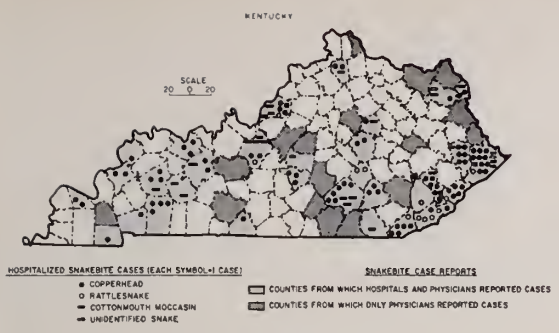


Figure 3. Geographical distribution of venomous snakebites in Kentucky, 1958 and 1959.

appropriate symbol is used to mark each hospitalized patient who was bitten by a specific kind of snake. The darker shaded counties are those counties from which physicians reported snakebite cases, but from which no cases were reported by hospitals.

Of 123 people hospitalized for snakebite treatment, 83 (67.5%) were bitten by copperheads, 12 (9.8%) by rattlesnakes, 3 (2.4%) by cottonmouth moccasins, and 25 (20.3%) by unidentified venomous snakes.

Copperhead bites were reported from all sections of the state. This is in keeping with their statewide distribution.

Most rattlesnake bites were reported from southeastern Kentucky from Harlan and adjacent counties. Five of these bites occurred while the victims were handling rattlesnakes during a church service. All of the rattlesnake bites were in the geographical range of the timber rattlesnake *(Crotalus horridus horridus).*

Cottonmouth moccasin bites were reported from Ohio, Muhlenberg and Jefferson Counties. The Jefferson County cottonmouth moccasin was imported from another area and bit the victim while being handled. The range of the cottonmouth moccasin is the western one-third of Kentucky.

Figure 3 shows that venomous snakebites happened most frequently in southeastern Kentucky in the Pike, Floyd, Letcher, Perry, Harlan, Bell County area. Another focus of snakebites is found in the Pulaski, Laurel, Rockcastle County area. Snakebites also are rather frequent in northcentral Kentucky around Jefferson and Hardin Counties. Another snakebite area is found in western Kentucky in Daviess, Ohio, Muhlenberg, Hopkins and Christian Counties. Thus, there are four multi-county, snakebite foci in Kentucky.

Table 1

Seasonal Distribution of Venomous Snakebites in Kentucky, 1958 and 1959.

Month	No. Bites	Month	No. Bites
January	0	July	40
February	0	August	26
March	0	September	19
April	2	October	2
May	14	November	1
June	19	December	0

Temporal Relationships

The monthly distribution of snakebite accidents is shown in Table 1. There were no snakebites during the colder months of the year—December, January, February, and March. Snakes are inactive and/or hibernating during the colder months. The first two snakebites were in April. A sharp increase in bites occurred in May when 14 bites were reported. Numerous bite accidents were reported from May through Spetember. The largest number of bites, 40, happened in July. There were two bites in October and one in November. However, two of these three bites resulted from people intentionally handling snakes.

An "epidemic" of venomous snakebites occurs during the warmer months of the year. This striking seasonal distribution of bites coincides with the time that snakes are most abundant and active and with the time that people have greater exposure due to out-of-doors occupations and recreation. Similar "seasonal epidemics" of venomous snakebites have been observed in New England and Florida.[2, 3]

Fifty-six (45.5%) of the snakebite accidents happened during the six hour period from 3-8:59 p.m. The number of bites by three-hour periods of time was as follows: 6-8.59 a.m., 11 bites; 9-11:59 a.m., 18 bites; 12 noon-2:59 p.m., 18 bites; 3-5:59 p.m., 29 bites; 6-8:59 p.m., 27 bites; 9-11:59 p.m., six bites. There were no bites reported from midnight to 6 a.m. In 14 cases the time of the bite accident was not recorded.

Bite Victims

There were 75 white males and 48 white females admitted to Kentucky hospitals for snakebite treatment during 1958 and 1959. No non-whites were treated in hospitals for snakebites during this two year period. Using the 1960 census of the population of Kentucky and the hospitalized snakebite patients, the bite rates per 100,000 population were 5.35

Table 2

Age Distribution of Hospitalized Snakebite Victims in Kentucky, 1958 and 1959.

Age Group (years)	Population at Risk*	No. Bites	Rate per 100,000**
0 - 9	668,207	34	5.1
10 - 19	567,494	33	5.8
20 - 29	368,022	9	2.4
30 - 39	383,540	15	3.9
40 - 49	351,138	12	3.4
50 - 59	298,690	10	3.3
60 - 69	220,605	7	3.2
70 or more	180,460	2	1.1
Not stated	——	1	—

*Based on the 1960 Census of the Population of Kentucky.
**These rates are based only on hospitalized patients for which information was available.

for white males and 3.39 for white females.

The finding that no non-whites were treated in hospitals for snakebites during 1958 and 1959 is not so striking when one realizes that only 5.7 non-white males and 3.8 non-white females would be expected to be treated for snakebites if the rates for white males and females are applied to their respective non-white populations.

The age distribution of Kentucky snakebite victims is shown in Table 2. The largest number of bites happened to children 0-9 years of age, 34 bites, and to those 10-19 years of age, 33 bites. Indeed, 67 (54%) of all snakebite accidents were inflicted on children and young adults less than 20 years of age. These figures are not as impressive when bite rates are calculated for these age groups.

Age-specific bite rates are much more meaningful since they take into account the population at risk in a particular age group. The highest biannual bite rates per 100,000 population were as follows: 10-19 years of age—5.8; 0-9 years of age—5.1; and 30-39 years of age—3.9. The lowest bite rate was for the 70 year and over age group.

An analysis of the occupations of the patients showed that 63 were children, 20 were housewives, eight were farmers or farm laborers, five were laborers other than farm laborers, three were retired, two were unemployed and two were professional snake handlers. The occupation was not coded for the remaining bite victims.

Activity and Place

Seventeen bites happened while children were playing outside but not in their own yards, and eight while playing in their yards. Eleven people were bitten while working on a farm, 11 while walking or working in their yards, eight while handling a venomous snake, seven while working or walking near a highway, five while reaching into an obscure place, four while picking up lumber or wood and three while engaged in recreation other than hunting and fishing. Two soldiers were bitten while participating in field training. The activity when bitten was not recorded for the other patients.

Closely associated with the activity when bitten is the place where the bite happened. The largest number of snakebites, 19, happened right in the patients' own yards. Sixteen occurred in the woods. Of 14 people bitten in or under a house or building, five were bitten in a church while handling venomous snakes during a religious ceremony, three were working in a barn, two were in their own houses, two were reaching under a house for an object, and two were handling captive snakes indoors. Eleven people were bitten on a farm away from the house, seven near or in water, seven near a highway, five in a field away from the house, and two in a field near the house. The place the bite happened was not recorded for the remaining patients.

Table 3

Anatomical Sites of Bites Inflicted by Venomous Snakes in Kentucky, 1958 and 1959.

Anatomical Site of Bite	Side of Body		Total No. of Bites
	Right	Left	
Head, face & neck	0	0	0
Trunk, front	0	1	1
Trunk, back	0	0	0
Upper arm	0	0	0
Forearm	4	4	8
Hand	10	8	18
Fingers	15	7	22
Upper leg	3	0	3
Lower leg & ankle	16	11	27
Foot	18	21	39
Toes	2	0	2
Not stated	—	—	3

Site and Severity of Bites

The anatomical sites where venomous snakes inflicted their bites are shown in Table 3. The sites of the bites were recorded for 120 of the 123 hospitalized patients. Of these, 119 (99%) people were bitten on the extremities, 48 (40%) on the upper extremities and 71 (59%) on the lower extremities. One 35 year old man was bitten high on his left shoulder while handling a cottonmouth moccasin.

The fingers and hands were the parts most often bitten on the upper extremities, whereas the foot and lower leg, including the ankle,

were the parts most frequently bitten on the lower extremities. The right side of the victims' bodies was bitten 68 (57%) times and the left side was bitten 52 (43%) times. Perhaps this is related to the right side being the dominate side of most peoples' bodies.

A modification of the clinical classification of pit viper venenations by Wood, Hoback and Green[4] was used to determine the severity of bites. Bites were classified as follows:

Grade O — *No venenation.* Fang or tooth marks, minimal pain, less than one inch of surrounding edema and erythema. No systemic involvement.

Grade I — *Minimal venenation.* Fang or tooth marks, severe pain, one to five inches of surrounding edema and erythema in first 12 hours after bite. No systemic involvement usually.

Grade II — *Moderate venenation.* Fang or tooth marks, severe pain, six-12 inches of surrounding edema and erythema in first 12 hours after bite, systemic involvement may be present; nausea, vomiting, giddiness, shock or neurotoxic symptoms.

Grade III — *Severe venenation.* Fang or tooth marks, severe pain, more than 12 inches of surrounding edema and erythema in first 12 hours after bite, systemic involvement usually present as in Grade II.

The classification of venenation (venom poisoning) for these 123 hospitalized cases was: (15%) were Grade O; 38 (31%) were Grade I; 30 (24%) were Grade II; 18 (15%) were Grade III; and the severity was not classified for 18 (15%) of the cases. There was one death among the 123 cases in this series, providing a case-fatality rate of 0.8%.

When one realizes, however, that approximately 36% of all venomous snakebite cases in Kentucky are managed on an out-patient basis, the case-fatality rate probably is about 0.5%. This is confirmed by the fact that there were only five snakebite deaths in Kentucky for the ten year period, 1950-1959.[5] Two of the five victims were bitten during snake handling religious ceremonies and did not seek treatment until it was too late. Perhaps they lacked faith—faith in antivenin! These findings tend to indicate that snakebite treatment in Kentucky is effective and/or that venomous snakes in Kentucky are not as lethal as formerly believed. We feel that both of these factors are operating in Kentucky to produce a low case-fatality rate.

Forty-six percent of the hospitalized snakebite cases were either Grade O or Grade I venenation and 15% were Grade III venenation. By way of contrast, 20% of the snakebite cases in Florida result in Grade III venenation.[2] Over 50% of snakebites in Florida were inflicted by rattlesnakes, but only 9.8% of Kentucky snakebites resulted from rattlesnake bites. In general, rattlesnakes produce more severe venenations than do copperheads. It seems likely that some of the bites by unidentified snakes in Kentucky were inflicted by rattlesnakes. This would help explain the relatively high proportion of Grade II and Grade III venenations in Kentucky. Or perhaps most of the unclassified bites were Grade O and Grade I venenations.

Treatment

The current treatment of North American pit viper (rattlesnake, cottonmouth moccasin and copperhead) bites includes both minor surgery and medical forms of treatment. A constricting band (tourniquet) should be applied lightly to the involved extremity several inches proximal to the bite. It should *not* occlude the arterial circulation and should be released every 10-15 minutes for a minute or two. As edema resulting from venom poisoning spreads, the constricting band should be advanced to keep just ahead of the swelling. The purpose of the constricting band is to impede the spread of venom until incision and suction can be used to remove the venom mechanically and/or until antivenin can be administered to neutralize the venom.

Incision and suction is effective in removing venom from experimental animals up to about 120 minutes after the venom is injected. The sooner it is used, the larger the amount of venom that can be removed. Suction should be used for about one hour. We have found the suction cups supplied in the Cutter and the Becton-Dickinson snakebite first-aid kits effective for removing pit viper venom. Incisions, one-quarter inch long and one-eighth to one-quarter inch deep, are made into the sub-

cutaneous tissues over the fang punctures. A few (3-5) additional incisions may be made in the surrounding edematous tissues. A large number of incisions is not needed. Immobilization aids in limiting the spread of venom. However, if one must decide between immobilization or seeking prompt medical treatment, the latter should be sought.

The "3 A's" (antivenin, antibiotics, and tetanus antitoxin and/or toxoid) are recommended, in addition to incision and suction, in treating all serious pit viper bites. Antivenin Crotalidae Polyvalent (Wyeth) is effective in neutralizing the venoms of all North American pit vipers. It is not protective against coral snake venom. Since antivenin is manufactured from horse serum, the patient should receive a skin test before antivenin is given.

For Grade I and Grade II venenations antivenin may be administered in the deltoid or gluteus muscles. In Grade III venenations, antivenin diluted in 1000cc. of normal saline may be given intravenously. Studies with radioisotopes have shown that antivenin accumulates at the site of the bit more rapidly after intravenous administration than after intramuscular administration.[6] We have found the following amounts of antivenin useful in treating the various Grades of venenation: Grade O (no venenation) requires no antivenin; Grade I (minimal venenation) may require 10cc. (one ampoule) of antivenin; Grade II (moderate venenation) requires 30-40cc. of antivenin; and Grade III (severe venenation) requires 50cc. or more of antivenin.

Since snakes' mouths and venoms may harbor pathogenic organisms, antibiotics and tetanus antitoxin and/or toxoid should be given prophylactically. Gram negative organisms predominate, hence a broad spectrum antibiotic is indicated. Penicillin used by itself is not adequate treatment.

Cortisone and ACTH do not affect the survival rate of animals poisoned with pit viper venoms. They probably should not be used during the first few days after venenation, although they may be beneficial later in treating serum sickness resulting from antivenin therapy. Antihistamines are contraindicated as they shorten the survival time of animals poisoned with pit viper venoms. Shock resulting from venom poisoning should be treated with infusions of blood, plasma, saline solution and vasopressor drugs. Meperidine hydrochloride and other analgesics may be given to relieve pain. Recently there have been reports of excessive tissue necrosis and amputations associated with cold therapy such as packing an extremity in ice or using ethyl chloride. In our opinion, cold therapy should not be used in treating pit viper bites.

Summary

An estimated 143 people are treated for bites by venomous snakes every year in Kentucky. Of these, 92 (64%) are admitted to hospitals for treatment and 51 (36%) are treated on an out-patient basis in hospital emergency rooms and in physicians' offices.

Of 123 snakebite victims treated in Kentucky hospitals during 1958 and 1959, 83 (67.5%) were bitten by copperheads, 12 (9.8%) by rattlesnakes, 3 (2.4%) by cottonmouth moccasins, and 25 (20.3%) by unidentified venomous snakes. Seasonal "epidemics" of snakebites occur in Kentucky with 118 of the 123 cases reported from May through September. Fifty-six (45.5%) of the bites happened during the six hour period from 3-8:59 p.m.

Males had higher bite rates than females and white people had higher rates than nonwhites. The occupational groups most frequently bitten were children—63 bites, housewives —20 bites, and farmers—eight bites. Ninety-nine percent of the bites were inflicted on the extremities—40% on the upper extremities and 59% on the lower extremities. There was only one death among the 123 hospitalized snakebite victims, a case-fatality rate of 0.8%. The case-fatality rate for all snakebite cases (hospitalized plus non-hospitalized) was about 0.5%. Current snakebite treatment is discussed.

References

1. Conant, R.: A Field Guide to Reptiles and Amphibians of Eastern North America, Boston, Houghton Mifflin Co., 1958.
2. Parrish, H. M.: On the Incidence of Poisonous Snakebites in Florida: Analysis of 241 Cases Occuring During 1954 and 1955. Am. J. Trop. Med. 6: 761-765, July, 1957.
3. Parrish, H. M., Badgley, R. F., and Carr, C. A.: Poisonous Snake Bites in New England. New Eng. J. Med. 263: 788-793, Oct. 20, 1960.
4. Wood, J. T., Hoback, W. W., and Green, T. W.: Treatment of Snake Venom Poisoning with ACTH and Cortisone. Virginia M. Monthly 82: 130-135, March, 1955.
5. Parrish, H. M.: Analysis of 460 Fatalities From Venomous Animals in the United States. Am. J. Med. Sci. 245: 129-141, Feb., 1963.
6. McCollough, N. C., and Gennaro, J. F., Jr.: Evaluation of Venomous Snake Bite in the Southern United States From Parallel Clinical and Laboratory Investigations: Development of Treatment. J. Florida M. A. 49: 959-967, June, 1963.

Four Lesser Venereal Diseases†

WILLIAM E. McDANIEL, M.D.
Lexington, Ky.

Four lesser venereal diseases are discussed, two of which may have devastating effects on the patient if unrecognized in the early stages and properly treated.

AS will be readily apparent when looking at the references surveyed from the world medical literature, the reports are few on the diseases here discussed. This doesn't mean, however, that case material is lacking; quite the opposite, for the references listed often report on from a score or two cases to near 200. Therefore, it is hoped this article will serve to heighten awareness of certain, not rare venereal diseases, two of which if unrecognized and properly treated may have devastating effects on the patient.

Lymphopathia Venereum

Etiology: A large virus immunologically related to those causing psitticosis and trachoma.

Course: One to two weeks (2-30 days) after sexual intercourse an evanescent, banal vesicle appears which ruptures readily, forming a small, shallow, rapidly healing ulcer, usually on the glans in the male or near the anterior forchette in the female (Figure 1). One to two



Figure 1. Primary lesion of lymphopathia vereneum is small elongated shallow ulcer on the left ventrum just posterior to the corona.



Figure 2. Bubo of lymphopathia venereum, hot, tender matted nodes about to develop multiple draining sinus tracts, usually unilateral as in this case.

weeks after this (may be as long as three months) a regional adenitis develops, usually unilaterally, but bilaterally in about one-third of the cases. (Figure 2).

In the male the inguinal glands become matted, fluctuant and tender, and the overlying skin hot and red (bubo) and multiple draining sinuses may develop. This may be preceded or accompanied by systemic symptoms of headache, fever, malaise, arthralgia and a widespread eruption of scarlatiniform or erythema multiforme type. The virus has been isolated from both blood and spinal fluid at this stage.

In the female a more sinister and ominous chain of events occur. The pararectal glands drain the external genitalia and spread retrograde from there. The outer coats of the rectum may become involved, resulting, in the course of a few years, in rectal stricture, causing pain, constipation and pencil like stools. During the acute adenitis stage, rupture of intrapelvic and pararectal glands may eventuate in rectovaginal fistula. In both sexes elephantiasis may develop.

Laboratory: Histopathologically there is a characteristic necrotizing granuloma in lymph nodes. Intradermal skin test with an antigen prepared from an infected chick embryo (Frei

*Assistant clinical professor of Medicine (dermatology), at the University of Kentucky College of Medicine.



Figure 3. Early verruca accuminata on inner foreskin.

test) becomes positive two to three weeks after development of the acute adenitis; this skin sensitivity persists for years. The complement fixation serological test becomes positive about one month after infection and remains at high titer for years. Both tests are highly specific though cross reaction with psitticosis and trachoma occurs. During and after the stage of acute adenitis there is hyperglobulinemia and A/G reversal.

Treatment: The tetracyclines and derivatives are very effective in the early stages: 250 mgm. every six hours for two weeks is given for the acute inguinal type: three weeks for the acute rectal type and if more chronic for at least six weeks. The prognosis is poor as the disease becomes more chronic. Surgery may be necessary for rectal stricture and elephantiasis.

Verruca Accuminata

Etiology: a filterable virus.

Course: From a few weeks to several months after sexual intercourse with one infected, small, pointed projections may develop, usually in the coronal sulcus (Figure 3), on the vulvar mucosa, perineum or perianally. These may multiply rapidly, especially during pregnancy or in a woman with a profuse discharge, to form a large vegetating, cauliflower-like growth. Malodor is common in the larger lesions.

Laboratory: On histopathological examination acidophilic bodies in cytoplasm and basophilic intranuclear bodies are seen in infected epithelial cells.

Treatment: 20% podophyllin resin is applied in ointment form or in collodion for short applications of two to six hours, depending on the location of the lesion and sensitivity of the individual, after which the area is washed with soap and water. Repeat applications at one to two weeks intervals are necessary often for all but small lesions.

Chancroid

Efiology: Ducrey's bacillus.

Course: A few days after sexual intercourse an inflammatory macule or pustule develops, usually on the glans or in the forchette. The pustule ruptures soon to form a non-indurated punched out ulcer which is painful. As the ulcer advances it assumes a more ragged appearance. Through auto-innoculation multiple similar lesions may develop (Figure 4). Regional adenitis, usually unilateral, (Figure 4), develops rapidly, going on to fluctuation and drainage.

Laboratory: Smears made directly from the undermined edges of the ulcer reveal numerous gram negative bacilli in chains giving the "school of fish" appearance. Intradermal test with a prepared vaccine becomes positive 10-14 days after infection and sensitivity remains for years.

Treatment: The tetracyclines are the treatment of choice and rapidly curative in doses of 250 mgm. every six hours for 6-12 days depending on whether lymph nodes have suppurated.

Granuloma Inguinale

Etiology: Donovani granulomatosis (Donovan bodies)

Course: Although the disease occurs in the



Figure 4. Chancraid: the smaller of the twa soft chancres is the result af auta-innoculatian where fareskin lay aver site of primary saft chancre in caranal sulcus. The red, hat, painful unilateral bubo is characteristic.

genital area primarily the transmission may possibly be by means other than sexual intercourse, e.g., the pubic louse. The incubation period is thought to be one to four weeks in most cases. The epidemiology isn't well worked out. A nodule forms with breakdown of overlying skin exposing a red, glistening granuloma (Figure 5). Autoinnoculation may lead to multiple lesions which become confluent through marginal spread eventuating in scarring and hypopigmentation with active disease scattered throughout. Before the advent of effective therapy metastasis to bone and internal organs led to demise of the patient in a few cases. Elephantiasis may be a late complication (Figure 6).

Granuloma inguinale constituted two to three percent of all veneral disease in negro inductees in a survey conducted in the late forties and early fifties and is seen predominantely in that race and in the southeastern part of the United States.

Laboratory: Multiple short encapsulated rods in the cytoplasm of mononuclear cells are seen on microscopic examination of scrapings from the active lesion stained with Wright or Giemsa stain.



Figure 5. Marked edema of genitalia (esthiomene) from chronic scarring of the progressive granuloma inguinale; near the anterior forchette on the left side is an active velvet red placque.



Figure 6. Early lesion of granuloma inguinale. a denuded red granulomatous placque.

Treatment: Tetracycline 2 gms. daily for a total of at least 25 gms.; more is necessary in extensive cases.

Summary

The salient clinical features, pertinent laboratory data and therapy of each of four less common veneral diseases are presented.

Figures 1, 2, 3 and 4 are courtesy of Dr. Ashton Welch.

References

1. Chemotherapy of venereal disease. Robt. Lees. Practitioner, London 188:53-57, Jan. 1962.

2. Penile lesions Among U.S. Armed Forces personel in Japan. Michael F. Barile et al. Arch. Derm, Chicago, 86:273-281.

3. Granuloma inguinale with a case report. J. S. Serma, Indian Practit, Bombay, 15:525_532, June 1962.

4. Lymphogranuloma venereum. A. Prigot and M. Marmell. Harlem Hosp. Bulletin, New York 2:1-9, Mar. 1961.

5. Granuloma inguinale with hematogenous dissemination to the spine. Bernard M. Kalstone et al. JAMA, Chicago, 176:530-532, May 13, 1961.

6. What is lymphogranuloma venereum? Frederick Vogel. Med Times, Manhasset, 89:696-698, July 1961.

7. Barium studies in intestinal lymphogranuloma venereum. H. Annamunthodo and J. Marryatt. Brit J Radiol, London, 34:53-57, Jan. 1961.

8. Group Specificity of Psittacosis-Lymphogranuloma Venereum Group Skin Test Antigens in Lymphogranuloma Venereum Patients. Maurice R. Helleman, Aston B. Greaves and Jacqueline H. Werner. J. Lab. & Clin, Med. 52:53-57, July 1958.

What's New and What's True of What's New in Dermatology†

Winston U. Rutledge, M.D.
Louisville, Ky.

The following article suggests the etiology of keratoacanthoma, notes the modern treatment of discoid lupus and psoriasis and describes some of the untoward effects of such therapy that must be guarded against.

SINCE many significant contributions to the theory and practice of Dermatology have been made in recent years it is difficult to single out the more important of these steps of progress to present, so I shall only mention a few that seem to me to be of particular value.

Keratocanthomas

The current Yearbook of Dermatology[1] has for its feature article a discussion of single and multiple keratocanthomas. These fast growing and rapidly involuting tumors appear to have been overlooked for many years. Perhaps they were mistaken for squamous cell carcinomas or some of the more benign growths which they closely resemble clinically. However, the history of their development, their tendency to disappear spontaneously and the rather characteristic microscopic picture they present will usually clear up the diagnosis.

The cause of this growth is still uncertain, but at present the possibility of a virus infection is foremost in the thoughts of many investigators. Recently, Zelickson[2] provided additional electron-microscopic evidence that intranuclear "virus-like particles" are present in the cells of keratocanthomas, but absent in squamous cell carcinomas. So far many attempts to reproduce this growth through the inoculation of tumor extracts have failed and Koch's postulates have yet to be fulfilled.

Why these tumors involute spontaneously is another question that is yet unsolved. Whether it is due to the development of a tissue immunity, as has been clearly demonstrated in the case of other virus-induced tumors, or whether the presence of products of cell necrosis, as has been recently described by Doctors Strauss and Appel,[3] can stimulate sufficient antibody response to effect this involution will require further study.

Finally, it should be reemphasized that when there is any question about the clinical diagnosis a biopsy should always be done and treatment based on the microscopic findings.

Lupus Erythematosus

Lupus erythematosus, especially the chronic discoid type, is another condition that is ever with us. In the past, when we had to rely on gold and bismuth for its treatment, the results were often far from satisfactory. The use of quinine by mouth and iodine solutions topically gave some encouraging results, and when the ravages of World War II cut off our supply of quinine an extensive search was instituted to discover other effective antimalarial drugs. From this investigation came Atabrine at first and later Chloroquine, Amodiaquin, Hydroxychloroquine and a combination of three of these drugs called Triquin.

In 1940 Prokoptchuck[4] was the first person to report the successful treatment of chronic discoid lupus erythematosus with Atabrine. Following that publication came many reports on the successful use of the other antimalarials

†*Presented during the First General Scientific Session of the Kentucky State Medical Association Annual Meeting in Lexington September 24-26, 1963.*

**Associate clinical professor of Dermatology and Syphilology at the University of Louisville School of Medicine.*

in the treatment of the disease. Some cases of lupus respond more successfully to one drug than to another—just why they work has yet to be explained, but they all act as anti-inflammatory and sun screening agents.

As in the case of many drugs, their beneficial effects have to be weighed against their harmful ones and the untoward reactions of the antimalarial drugs must always be kept in mind. I shall not attempt to enumerate all of the harmful possibilities but since Chloroquine Phosphate is perhaps the antimalarial most widely employed it is important to stress the eye changes that frequently develop during its use and to emphasize the importance of periodic eye ground and visual field checks since the earliest eye changes are reversible while the later changes are irreversible and may progress even after the administration of the drug is stopped. It is also wise to mention that the uncontrolled use of this drug should be guarded against as unfortunate medico-legal complications may follow such a practice.

These drugs are also effective in treating polymorphous light eruptions and those rare cases of light sensitive psoriasis that are helped rather than harmed by the antimalarials.

Steroids

Steroids are the drugs-of-the-hour and before their development the practice of dermatology was a far more complicated procedure than it is at present. Fortunately they came along about the time that radiotherapy was falling into disrepute and their use has successfully replaced the roentgen ray in the treatment of many skin diseases.

Aside from their employment in the collagen diseases and pemphigus, the prolonged systemic administration of the corticosteroids is frowned down upon by modern dermatologists. On the other hand, their transient use in such acute allergic disorders as ivy dermatitis is to be recommended as they give marked symptomatic relief and produce no harmful sequelae when used but briefly.

The most recent dermatological employment of the corticosteroids has been by intralesional injection and topical application with occlusive dressings.

The latter procedure has largely replaced the former since intralesional injections are occasionally followed by objectionable skin atrophy, needle syncope and chest and lumbosacral pains, as have been described by Leon Goldman, M.D.,[5] of Cincinnati.

In such diseases as psoriasis, hypertrophic lichen planus, lichen chronicus simplex and chronic discoid lupus erythematosus the occlusive dressing technique produces gratifying results. Formerly these dressings were left intact for five to seven days, but the malodorous results from such prolonged applications plus the occasional miliaria, folliculitis or furunculosis that developed have resulted in the more frequent changing of such dressings and the thorough cleansing of the treated area before the dressing is reapplied.

Not all of the steroid preparations are equally effective in this procedure. The recently developed fluorinated s t e r o i d s, fluocinolone acetonide (Synalar®) and flurandrenolone acetonide (Cordran®) perhaps give best relief.

The details for the application of these preparations are precise and exacting and must be followed meticulously to obtain optimum results.

The title of this exposition included "What is True of What is New". To the best of my knowledge all of the above is true. Germane to this point is the recent work of Clarence Shaw, M.D.,[6] of Chattanooga. He did a double blind study on the use of Lipan in the treatment of psoriasis. He found that an administered placebo was as effective as this lipotrophic enzyme in the clearing of this disease. It was an interesting study and serves to remind us to accept with moderate skepticism some of the glowing reports that emanate from the advertising departments of the drug manufacturers today.

References

1. Year Book—Dermatology, 1962-63: 7-35.
2. Zelickson, A. S.—Journal Invest. Dermat., 37:79-83, 8/61.
3. Strauss, Alfred A., and Appel, Max—Michael Reese Hospital, Chicago, Ill., Abstract-Modern Medicine, 7/8/63:13.
4. Prokoptchuck, A. J.—Traitment du Lupus Erythemateux par l'acriquine—Vestn. Derm. Vener., 2/:23—1940.
5. Goldman, Leon—The Management of Psoriasis and Current Concepts Regarding Occlusive Methods of Treatment—A Round Table Discussion—Syntex Laboratories Inc., 6/62: 14.
6. Shaw, Clarence — Arch. Derm. 87: 462-465, 1963.

The Education and Training of Physicians and Psychiatrists For Community Psychiatry†

Bernard C. Holland, M.D.* and Robert A. Porter, ACSW**
Atlanta, Ga.

To teach a resident community psychiatry we have the following goals: 1) motivate him to be openminded about social problems, 2) teach him social organization, 3) teach him how to apply clinical knowledge to social problems.

A WELL trained psychiatrist should have a basic understanding of abnormal and normal human behavior and the methods by which behavior can be influenced in the direction of mental health. Social problems such as dependency, mental illness, divorce, delinquency, poverty, and criminal behavior are suspected of having a large element of unsolved emotional disturbances or mental illness as a part of their cause. Community psychiatry is the application of clinical knowledge of the psychiatrist to the analysis of, treatment of, and prevention of social problems.

Goals

With this as a working definition, there are several general goals which we would like to attain in the teaching of the resident. These are to: 1) motivate him to be open minded in his approach to social problems; 2) increase his knowledge and understanding of social problems through social research; 3) teach him about the nature of specific social problems; 4) give him an insight into social organization; and 5) teach him the methodology of applying clinical knowledge to social problems.

1. Attitude toward social problems. The chief consideration here is to inculcate in the resident a scientific attitude when he studies social problems. While the resident may possess curiosity, objectivity, and openmindedness with reference to clinical psychiatry, it is not safe to assume that he will also have this same objectivity with reference to community psychiatry. The resident may be deeply concerned with the social problems of a patient; but once these social problems are abstracted and generalized to a total group in our society who are affected by these problems, the resident is likely to view them with an entirely different perspective. For example, if a patient is poverty-stricken and if poverty is contributing to the stress of rearing the family, the resident is likely to be concerned about the poverty. However, when the social problem of poverty is abstracted and generalized, the resident is less likely to have the same type of concern. The resident's fixed attitude may block him from looking scientifically and objectively at the extent of the problem, especially if the solution to the social problem might be very controversial. With such an attitude, open minded scientific inquiry cannot develop.

2. Social Research. This assumes a rather different complexity from that of clinical research, which tends to center about the analysis and collation of data in case studies. Social research is likely to involve more complicated formulations of research design, problems of definition and classification, statistical procedures, etc. The study by Hollingshead and Redlich on social class and mental illness would be a good illustration of this. Social research methodology is the basic instrument for in-

† *Presented at the September 24 meeting of the Kentucky Psychiatric Association during the Annual Meeting of the Kentucky State Medical Association in Lexington September 24-26, 1963.*

* *Professor and chairman of the department of Psychiatry at Emory University School of Medicine, Atlanta, Georgia.*

** *Director of social service, department of Psychiatry at Emory University School of Medicine, Atlanta, Georgia.*

creasing our knowledge and understanding of social problems.

It would also be our purpose to motivate the resident to be curious about and to be highly motivated toward finding solutions to social problems. If the resident is exposed to a specific social problem, because of the impact of this social problem on the patient's emotional state, the resident is likely to be aroused to offer help. For example, a woman is distressed because her husband has deserted her, and there is no support for herself and her children. The patient is only an instance of the common social problem, desertion. The total problem must be presented to the resident, utilizing the particular individual or group being seen as an instance of the problem and as a direct way of eliciting arousal patterns in the resident.

A part of the attitude toward social problems should be one of hope that with time, effort, and the application of scientific knowledge, some of our current social problems may be solved. It must be emphasized that hope describes accurately all that we can expect from our current knowledge. Judging from our past experience in the physical health field, through study, research, and social action we have been able to prevent many physical illnesses.

We have not yet demonstrated that many of the social problems that we now have can be prevented by the scientific approach of our understanding of human behavior. Prevention is something beyond rehabilitation, which in itself may be regarded as a form of prevention. Psychiatry has a wealth of knowledge concerning behavior and the social stresses which create mental illness. Many programs such as child welfare, public welfare, and care for the aged have been designed on the basis of some of the implications of psychiatric knowledge. Many of these programs are not as effective and efficient as they should be. It may be that psychiatry, with diligence, could make a contribution to making these programs more effective.

3. The third general goal of the education and training for community psychiatry should be to teach our current knowledge about specific social problems. Some of our social problems are health (physical), welfare (dependency), recreation, maladjustment (including mental health), unemployment, and criminal behavior. Some of the social factors which contribute to the social problems are deprivation, neglect, lack of opportunity, and possibly oppression. The main result for the individual so affected is a sense of low self esteem, dependent attitudes, ignorance, failure at work, at home, as mother and father, and an increasing sense of resentment.

The resident who would learn something about community psychiatry should be acquainted with the nature and scope of each of these problems, the historical evolution of the problems, and the manner in which Western civilization has attempted to cope with them, and should assess the effectiveness of existing arrangements in the light of his expert knowledge of psychiatry, and determine gaps in service as well as any modifications, extensions, or deletions that would be indicated in the light of present day knowledge. I feel that if these problems are effectively and competently presented, the prospect of the resident's engaging himself emotionally and intellectually in these social issues is very good.

4. Theory of Social Organization. A knowledge of organizational theory is important for the consultant as a source of new insights for administrative changes and program planning. In this context Lucille Austin sees bureaucracy as "a formal organizational system which strives to clarify roles, distinguish between superiors and subordinates, and locate power in proper centers." Also, in this sense, the organizational system is seen as a social system and can be studied as such. Like other social systems, it has value orientations, defined role relationships, rewards and punishments, prescribed forms of behavior in set situations, and channels of communication, which shape the behavior of its members and give it character.

Community organization is largely a study of those factors which affect or can be used to effect social change. Social planning, particularly as this relates to programs designed to alleviate and/or prevent emotional illness, hopefully grows out of social research. A knowledge of the de facto power structure of the community, how it can best be dealt with and educated, etc., is an important component of planned change in institutional patterns which have a direct effect on social behavior.

5. Methodologies for transfer of knowledge. Any number of significant methods, or combinations of methods, might be used to transfer or to apply psychiatric knowledge to the understanding and resolution of social problems. The

resident should be encouraged to develop competence — certainly more than a makeshift knowledge—of as many of these methods as possible. Among these are consultation, conference participation, seminars, social research, community organization, social action, clinical demonstration, and direct service as a basis for teaching. A comment on some of these:

Effective consultation is a highly developed skill involving an awareness of administrative principles, group process, and, depending upon the nature of the consultation, a knowledge of bureaucratic theory. It may also involve a knowledge of learning theory as well as of other methods listed above, again depending upon the nature of the consultation. Outside the framework of this larger body of knowledge, consultation may not only be ineffective, but disruptive.

Methods of Teaching

Methods of teaching community psychiatry to residents. The curriculum of any professional school (i.e., the service professions) is generally divided into two broad categories: 1) the educational program emphasizing content offered through classroom instruction, and 2) an orderly sequence of increasingly complex learning experiences which permit the learner actively to engage himself intellectually and emotionally in the external conditions or problems which are the concern of his profession. Through actual practice, usually under supervision, he begins to integrate academic content with developing skills with which he will extend the service of his profession.

What are some of the learning experiences which would serve as effective means of integrating content and developing skills in community psychiatry, as defined above?

1) Orientation to existing social service programs. What are the social problems which the agency has been designed to deal with? What is the effect of these social problems on the individuals or groups the agency serves? What method, or methods, does the agency use to help the individuals or groups it serves? How effective are these methods in terms of results? What are the gaps in service and what obstacles does the agency contend with in implementing its program? What does the agency understand of the causative factors of the social problems of its clients? What research does it conduct? Is there a program of prevention? Does it participate in social planning in the relevant area of its function? How does it do these things? What contribution can psychiatry make to this complex of tasks?

In reference to the complex of social agencies, how are these agencies interrelated? How flexible and adaptable are they in terms of modifying program to cope with changing and emerging social need? What functions appear obsolete in the light of changing social need and the present state of scientific knowledge?

2) Direct service to clients of the agency, largely as a means of studying the impact of social problems on the individual and as a basis for exploring ways in which psychiatry can contribute to the understanding and treatment of these problems. These services would be largely diagnostic in nature. Group therapy with selected clients might also be a rewarding learning experience, providing a more intensive understanding of the social problems of the group members.

3) Consultation to staff with reference to cases, program planning, research activities, personnel and administrative structure as these might benefit from the wisdom of clinical or social psychiatry.

4) Formal seminars in psychiatric aspects of problems with which the agency is concerned.

5) Supervision of staff in casework or group treatment involving clients with emotional difficulties and psychiatric disorders.

6) Initiation of or participation in social research activities through the facilities of the agency.

7) Community Organization. If the resident has a direct experience in working with the community organization, he will be exposed to the fact that power struggles, conflicts of interest, budget conflicts, etc., have a direct effect on any program of care which he would like to implement. These are very sobering experiences, but they will help the resident to understand that the application of a special knowledge which he has takes time and prolonged effort in order to secure social action.

8) Social action. Methods of influencing the power structure with reference to needed social change.

Other learning experiences can be conceived as legitimate training in methods of social psychiatry, though I think experience in the above activities constitute a sound basis for further growth and development.

Mass Glaucoma Screening in Kentucky†

JAMES LEE STAMBAUGH, M.D.*

Lexington, Ky.

The keys to success of this program were splendid professional and lay co-operation and a thorough follow-up procedure.

IN September 1962 the first mass glaucoma screening program in Kentucky was successfully executed. Its unique features were: testing in a State Fair environment; use of Tonofilms®;** and excellent follow-up.

Any one of the participants in this project could report our experiences to you today. I am merely acting as a representative of a group of enlightened and interested individuals who were collectively responsible for its success.

Under the able chairmanship of C. Dwight Townes, M.D., planning and meetings began nearly a year in advance, and culminated in sponsorship by the Kentucky Society for the Prevention of Blindness, supported by the National Society for the Prevention of Blindness, the United States Public Health Service, Kentucky State Health Department, University of Louisville School of Medicine, the Eye, Ear, Nose and Throat Section of the Kentucky State Medical Association, and lay volunteer organizations.

Publicity was built up for nine months before the project, and included spot radio and television announcements, special programs, and articles in newspapers and farm publications with a local and statewide distribution. A small-scale trial run was carried out five months before, in which 243 persons attending the Kentucky Public Health Association meeting were tested. Comprehensive public and professional liability insurance was secured at modest cost.



Figure 1. The Tonofilm® is a very thin rubber membrane which is placed over the entire lower end of the tonometer. Each one is individually packaged and sterilized and is discarded after tonometry on one patient.

Method of Screening

The screening program was operated daily for the nine-day duration of the Fair, from 2:00 to 10:00 p.m. It was conducted in a semi-screened area near the center of a large enclosed pavilion, in relation to exhibits dealing with ethical aspects of health, and collectively called "Health-O-Drama." Screenees were 40 years or older, except those with a family history of glaucoma, who eventually accounted for three percent of the total. An IBM card, sponsored by the United States Public Health Service, was initiated on each subject and the

---

†*Presented at the September 26 meeting of the Kentucky Eye, Ear, Nose and Throat Society during the Annual Meeting of the Kentucky State Medical Association in Lexington September 24-26, 1963.*

**From the section of Ophthalmology at the Lexington Clinic, Lexington, Ky.*

***Manufactured by the American Bio-Chemical Laboratory, Inc., Baltimore, Maryland.*

final data later transferred to the appropriate punch-out slots by volunteers. Screenees were registered by one of two volunteers of the county Medical Auxiliary, then given pertinent material explaining the nature and significance of the test.

Visual acuity was recorded for each eye, with glasses if the subject wore them for distance. This was felt necessary for medicolegal purposes and was not considered as a referral criterion.

Two ophthalmologists served each four-hour shift, each using two reclining ophthalmic chairs. Tonometry was performed only by them, after instillation of proparacaine (Ophthaine®) for anesthesia. All tests were with Schiotz tonometers bearing 7.5 gram load, certified and recently checked for accuracy. Tonofilms, individually packaged and sterilized, were used exclusively.

Negative screenees were so informed and were offered pertinent literature supplied by the Kentucky Society for the Prevention of Blindness as they left the testing area.

Persons having a tension of 21.9 mm. or greater were considered suspect, and were immediately counseled by a public health nurse, who again pointed out that the test was of a screening nature only. If the suspect named an ophthalmologist, he was advised to consult him; if he knew none, he was advised to consult his family doctor, and was offered a list of all ophthalmologists in the state. In either case the doctor named by the testee was sent a letter, which was mailed from the Fairgrounds the same day, giving him the results of the test and enclosing a report card for return following his disposition of the case.

No further action was taken for three months. A letter was then sent to those suspects not yet reported on; and six weeks later those still pending were contacted by telephone. If they had still taken no action their cases were referred to the local health department nurses for personal contact and follow-through. All cases were closed only on a physician's verification.

Results

During the nine-day period 4,440 individuals were tested; 338, or 7.6 per cent, were positive by the stated criterion. There was one questionable reaction to the anesthetic drops used. No corneal abrasions, infections, or other complications were brought to our attention. The Tonofilms were uniquely successful. For most of the ophthalmologists this was their initial experience with Tonofilms, and it is noteworthy that while many approached their use with certain misgivings most readily adapted to their use and acknowledged their advantages. Use of Tonofilms did not significantly slow the testing procedure, which in sample timings required three to nine minutes from registration to exit from the test area.

The follow-through has been thorough. A gratifying 52 percent of the suspects were closed out by return of the original report card sent to the physician, without the need for further follow-up procedure. Subsequent letters and phone calls resulted in disposition of another 33 percent. Only nine percent have been referred to local health department nurses.

Of the 338 suspects, 61 (18.5 percent) have been established as having glaucoma, and another 73 (21.6 percent) have been classified as possible glaucoma and/or requiring further evaluation. This means that three percent of the total number screened either had glaucoma or had findings sufficiently suspicious to warrant continued observation.

Six other Kentucky communities have conducted screening projects, and several others are planned.

The 1963 State Fair program was completed recently. The methods were essentially the same. Based on the observation that the average mortal is reluctant to enter an enclosed maze of presumed hazards, the area of tonometry was rearranged to be completely visible to potential candidates for testing. Three ophthalmologists performed tonometry in six chairs.

Until the last three days of this year's Fair, the number screened was running 1,000 ahead of a year ago. Then a bad turn of weather sharply decreased general Fair attendance and was reflected in this program. The total of 4,379 screened in 1963 is slightly less than one year ago, and the 223 suspects (5.1 percent), is considerably less. These results are summarized in the following table.

Table I

1962	Total Screened:	4440
	Suspects:	7.6%
	Of the Suspects—	
	Glaucoma:	18.5%
	Possible:	21.6%
1963	Total Screened:	4379
	Suspects:	5.1%

Project Observations

Several noteworthy points have emerged from these projects:

The cooperation of all organizations and individuals has been magnificent. Detailed advance planning and close liaison of all participating groups is essential.

Use of Tonofilms in mass tonometer screening is practical and enhances the safety of the test.

There were no complications, despite testing in a "Fair" environment that certainly was less than ideal.

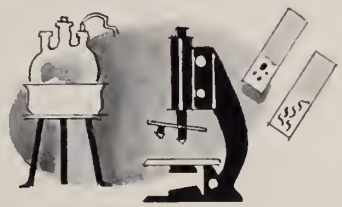
Lay volunteers can accurately transfer information to data processing cards.

In a statewide mixed rural and urban setting a follow-through method employing report forms, letters, and telephone calls resulted in disposition of 91 percent of the cases in the first large-scale project.

Only two suspects consulted a non-medical practitioner rather than an ophthalmologist.

A properly-informed public responds well to a systematized method of glaucoma detection.

Altogether over 12,000 Kentuckians have been tested and individually exposed to the facts of glaucoma. While the detection of new cases of glaucoma is the obvious immediate result of such a program, a most valuable dividend is increased public awareness of this insidious disease, and the emphasis on its early detection and proper management. Undoubtedly more individuals are thus stimulated to seek professional eye care, and this is after all the major key to the prevention of blindness, to which we are all dedicated.



Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.



CASE DISCUSSIONS
From The
University of Kentucky Hospitals



University of Kentucky Hospital

Depression Masquerading As Apathy

Hugh A. Storrow, M.D.*

THE patient was a tiny doll-like woman with long black hair and large eyes. The hospital face sheet gave her age at 36, but she looked younger. Her face was expressionless as she talked rapidly and almost incoherently. I could follow some of her statements, however, and the story began to emerge.

"I've lost all my feeling," she said. "I don't care for my children or my husband any more. I've lost my nature, too; I don't care about sex at all."

Mrs. L. had been ill for two years with essentially the symptoms she described on admission. She had received a variety of tranquilizers and anti-depressants without much benefit although she felt that the medications had helped her to remain at home doing her work. Because her physician had left her community, she had received no treatment during the three months prior to admission.

One week before I saw her, Mrs. L.'s stable symptom pattern had changed abruptly. She was suddenly convinced that her home, her furniture, and all her possessions were outstandingly beautiful. She began to chatter about this conviction, talking rapidly and laughing inappropriately. Her family had previously wondered if she might be exaggerating her symptoms; now they became concerned enough to seek further medical attention.

Mrs. L. presented us with a knotty diagnostic problem. Unfortunately, diagnosis in this case was not simply an academic exercise; it would be an important guide to effective treatment. Was her lack of "feeling" the apathy frequently seen in schizophrenic patients? Or, was she really "depressed?" At first the evidence seemed to point to schizophrenia. Associations were somewhat loose, although abstract thinking as measured by proverb interpretation was not markedly impaired. She expressed the apparently delusional conviction that "the Lord has taken my feeling away." The past history gave further support. Mrs. L. had always been considered the "odd" member of her family. She stayed close to home, had few friends, and dated rarely. When psycological test results became available, they provided the apparent "clincher." Although some depression was evident, the pattern of responses pointed to schizophrenia. Loose associations were present and the responses were peppered with anatomical content: visceral, sexual, and anal.

Since Mrs. L. had apparently never received an extended course of phenothiazines in subtantial dose, I decided on such a program in combination with psychotherapy. I chose trifuoperazine (Stelazine) because of its alleged effectiveness in withdrawn apathetic patients. Psychotherapy quickly uncovered a wealth of "dynamic" data which for a time distracted attention from the fact that the patient was becoming worse, not better. The present illness began when the patient joined a fundamentalist church following a public profession of faith. She felt that this meant she was now "trapped" and that she would have to be "good" for the rest of her life. Although she was a meticulous perfectionistic person who spent her life trying to please authority figures, she felt she had never succeeded. She was furious at real or fancied criticism from her husband, her parents, and her neighbors, but she had never expressed these feelings openly.

Mrs. L. did not respond either to medication or interpretation, and retreated more and more to her room. Almost incoherent shouts about her lack of feeling, her conviction that the "Lord" had abandoned her, and her fears of

*Associate Professor of Psychiatry, University of Kentucky Medical Center, Lexington, Kentucky.

approaching death reverberated up and down the hospital corridor. These alternated with child-like pleas for help.

The initial diagnosis was obviously open to question. A number of anti-depressant medications were tried—imipramine (Tofranil), amitriptyline (Elavil), and tranylcypromine (Parnate)—both alone and in combination with phenothiazines. Symptom intensity varied; at one point Mrs. L. improved sufficiently to return home for a trial visit but promptly relapsed while there. The nature course of the illness was evidently unaffected by any of the medications used.

At this point I withdrew all medication and began to prepare the patient for electroconvulsive treatment. A visiting consultant who saw the patient supported this decision and pointed out that affective disturbances are frequently associated with apathy rather than frank elation or depression.* Mrs. L. received ten electroconvulsive treatments spaced over a period of 18 days. The first three treatments were given daily with longer intervals between subsquent treatments. Atropine was used for premedication with thiopental sodium (sodium pentothal) for anesthesia and succinyl choline chloride (Anectine) for muscle relaxation at treatment times. Although Mrs. L. welcomed this therapy at first, she became fearful toward the end of the series. She also gradually developed the mild confusional state often seen with electroconvulsive treatment. This had subsided completely at the time of discharge.

Improvement was progressive. Disturbed, agitated behavior disappeared. Mrs. L. began to look forward to visits from her family and to want to return home. Although she continued to complain of lack of feeling for her family which she described as "emptiness in my chest," this no longer seemed to bother her very much.

Mrs. L. was discharged after four months of hospitalization. She has since remained under the care of a psychiatrist near her home who has treated her with psychotherapy plus medication consisting of amitriptyline (Elavil) and perphenazine (Trilafon). Symptoms did not recur for six months following discharge although the patient had to cope with a serious family crisis during this period. More recently, symptoms have begun to trouble the patient again. The attending psychiatrist feels that another episode of depression may be beginning and that hospitalization for another course of electroconvulsive treatments may be necessary. Recurrent episodes are a characteristic feature of many depressive reactions.

In retrospect it appears that this patient was suffering from a primary affective disorder characterized by apathy rather than by frank elation or depression. The short period of excited behavior immediately prior to admission was apparently a brief hypomanic episode. Since a careful history failed to yield any evidence of other previous elations or depressions, the discharge diagnosis was psychotic depressive reaction. The possibility of an associated thought disorder remains, of course, although there was no clear-cut clinical evidence for this up to six months following the course of electroconvulsive treatments. It seems likely that Mrs. L.'s illness could have been shortened considerably if the diagnostic problem had been cleared up and electroconvulsive treatment used earlier, either during her hospitalization or during the two years period preceding admission. A further important point demonstrated by this case is the fact that electroconvulsive treatment will frequently produce a remission in an affective disorder when the antidepressant drugs fail.

*Leslie B. Hohman, Professor Emeritus of Psychiatry, Duke University Medical Center, Durham, North Carolina.

Reference

1. Hohman, L. B. and Wilson, W. P.: The Varieties of Affective Disturbances. Southern Med J, 55:307, 1962.

SPECIAL ARTICLES

Nursing Home Administration Enhanced By Michigan State University

CARRIE C. CALVERT*

THIS is the story of nineteen people who pioneered in a six-weeks conference dealing with many phases and aspects of nursing home administration. Eleven states were represented in this campus activity at Michigan State University, East Lansing, Michigan.

From what background did these people emerge? Taking one economic factor as a measure, over eleven million dollars in nursing home establishments was the personal investment of the class.

Three agencies sponsored the confrence. They were the United States Office of Health, Education and Welfare; the American Nursing Home Association; and Michigan State University.

The heaviest emphasis was placed upon accounting. Actually, this subject was the key to the entire course. Of the 300 hours of the conference instruction, accounting was taught for 60 hours. Why this concentration on record-keeping, purchasing, inventory control and time study? One member of the faculty, a physician, explained it this way: "Better management can be had through accounting analysis than on the spot supervision." This doctor owns five nursing homes and is successfully operating them.

Forty hours of the course were devoted to personnel and public relations matters. The psychological overtones and implications were very fascinating. We learned about work simplifications and organizational procedures. In centive pay was discussed in an interesting perspective. Job responsibilities were planned and plotted in different nursing home situations. Several "do-it-yourself" projects frutifully emerged from this line-staff study.

Family and patient counseling were included in the field of public relations. A practical affiliation was outlined relevant to physician, hospital, and nursing home. This relationship is an essential one and must be improved as far as the nursing home is concerned. The image of our collective services will be heightened when attitudes and services become more professional.

Diet and food, diversional therapy, nursing, housekeeping, institutional maintenance and communications also received proper attention. These were correlated effectively by our instructors.

Along the subject matter line, religion was not overlooked in our general consideration. The total person, and his care, deserves many attentions, the religious not being the least. This theme was echoed throughout the lectures and discussions, the theme of many attentions.

There is no doubt that the six-weeks course widened our views and deepened our understandings. It fired our sense of inquiry. It sharpened our skills. Our appreciation for the word "home" in nursing homes was increased even more.

Through good management, organization and personal relationship, better service will evolve. We saw proof of this from actual records. Better service for patients means more and better business. How to acquire this acumen is not a thing to be learned in six weeks, it is true, but in-service provisions of this nature are steps in the right direction. Open-mindedness and a sense of inquiry gained at this Nursing Home Administrators Conference was the biggest "take-home" value.

*Director, Nursing Home Consultant Services, Louisville, and Adminisrator, Mt. Holly Nursing Home, Louisville.

EDITORIALS

The Thymus—Master Gland Of Immunity?

THE thymus has been an organ of mystery for centuries and until recently no better definition of its function was available than that of Galen who stated that it acted as a cushion between the sternum and the great vessels. The recent intense interest in organ transplantation and in the problem of homograft rejection has stimulated renewed interest in thymic physiology.

The relative size of the thymus is greatest at birth, the absolute size is maximum just before puberty, and the gland then atrophies with advancing age. Microscopic examination reveals a cortex consisting of lymphoid follicles, which under normal conditions do not have germinal centers. The medulla of the gland consists of loose reticular tissue through which are scattered Hassall's corpuscles. The function of these corpuscles has been a source of speculation for many years and investigators have searched in vain for evidence of an endocrine secretion. Atrophy of the thymus with age involves mainly the cortex so that the lymphoid follicles gradually disappear, but Hassall's corpuscles can be identified at all ages.

Ordinarily the function of an organ is studied by its removal, observation of the deficiency state produced, and replacement therapy. The experimental investigation of thymic function was hampered by the fact that thymectomy in adults apparently caused no deficiency state and extracts of the gland failed to produce demonstrable changes. However, certain relations between the thymus and the endocrine glands have been established. Hyperthyroidism is associated with enlargement of the thymus, which is believed to be related to inactivation of thyroid stimulating hormone by the thymus. Adrenal cortical hyperplasia and corticosteroid therapy cause thymic atrophy because of the lympholytic effect of the adrenal hormones. On the other hand, the thymus is enlarged in states of adrenal cortical insufficiency, a relationship that has been considered significant in the problem of status thymicolymphaticus. Testosterone and estrogens are mildly thymolytic. Prefrontal lobectomy in animals leads to enlargement of the thymus and the lymphoid tissues and there is one report of a human who shot himself in the head necessitating a surgical prefrontal lobectomy: when this individual died of other causes several months later the thymus was greatly enlarged.

Recent investigation of the role of lymphoid tissues in homograft rejection once again directed attention to thymic function. In the experimental animal thymectomy in the neonatal period, that is between birth and the third day, resulted in a marked alteration in the animal's immune defense mechanisms. Depression of the response to viral and bacterial stimuli and to allogeneic and heterogeneic skin grafts occurred. Homografts were accepted, lymphopenia developed, and the number of lymphocytes in the spleen and lymph nodes was greatly decreased. The animal died of a wasting illness like "runt disease." In the neonatal chicken, removal of the bursa of Fabricius, an organ similar in structure to the thymus but located posterior to the rectum, impaired the animal's antibody production.

Thus, removal of the thymus gland in the neonatal period resulted in failure of development of the immune defense mechanisms. Subsequently, attempts were made to restore the animal to normal. Neither saline extracts from the thymus nor cells from the neonatal gland were effective, but a thymus graft implanted in the first week restored the immune mechanisms. If the donor and the host were of the same strain, skin grafts from all other strains were rejected; but if the donor and host were of different strains, skin grafts from both of these strains were accepted while those from other strains were still rejected. Injection of lymphocytes from normal adults also restored immunity to an animal that had undergone neonatal thymectomy if administered within the first week.

After neonatal thymectomy and thymic im-

plantation within the first week, development of lymphoid tissues proceeds at a normal pace. Are the lymphoid tissues recolonized from cells of thymic origin, or do the lymphocytes arise from the host with the assistance or stimulation of the grafted thymus? This question has been partially answered by experiments involving the T6 strain of mice. A group of T6 mice, which have an easily identifiable marker chromosome at the metaphase of cell division, underwent neonatal thymectomy followed by thymic grafts within one week from another strain of mice that did not have this marker chromosome. It was found that 80 to 100 percent of the cells in the thymus and lymphoid tissues originated in the host and thus that the host cells were responsible for the subsequent immunological reactivity of the animal.

It appears, therefore, that cells of immunological potential remain in the animal that has undergone neonatal thymectomy, but this potential cannot be expressed in the absence of the thymus. That these cells probably reside in the marrow is demonstrated by the following experiment. Total body radiation was given in a lethal dose to destroy completely the blood cell production in the marrow of experimental animals. An intravenous injection of bone marrow resulted in repopulation of the marrow with red blood cells, neutrophils, and platelets, as well as reappearance of lymphocytes in the blood stream and nodes. However, if a prior thymectomy had been performed, the red blood cells, neutrophils, and platelets reappeared after marrow injection but the lymphocytes did not return.

The conclusion drawn from these experiments is that, after neonatal thymectomy and subsequent thymic graft, host cells invade the thymus and find an environment that is suitable for lymphoid differentiation and multiplication so that full immunological competence is eventually regained. Another hypothesis, suggested by Metcalf, is that the thymus produces a lymphocytosis—stimulating factor that promotes lymphocytic growth. However, neither homogenates of the thymus nor extracts of the gland have yet produced any change in the lymphocyte count in normal or thymectomized animals.

Thymectomy in the adult experimental animal does not greatly affect its immune response. If at least three weeks elapse from birth to thymectomy, only a temporary lymphopenia and a decrease in the weight of the spleen and lymph nodes result. Homografts are rejected and antibody levels are normal or slightly decreased. Even at this stage, however, the thymus has some function in immunity. If a sublethal dose of total body radiation is administered to an adult experimental animal, the immune response is temporarily depressed and then recovers completely. If the animal has undergone a prior thymectomy, recovery from sublethal radiation is slower and the degree of immunity finally achieved is frequently less than normal.

At this point it is necessary to review some of the theories of antibody production. The Instructive theory postulates that the antigen acts as an instructor or template on which the antibody is formed and that all antibody production is acquired after birth on the basis of exposure to the antibody. The tissues of the individual himself have certain characteristics or self-markers that distinguish them from foreign tissues, and antibody production against "self" is forbidden. The other hypothesis is the Selective theory popularized by Burnet, in which the antibody capabilities are considered to be a genetic endowment. The stem cells give rise to clones or families of cells capable of forming antibodies. At birth, clones are present that are capable of forming specific antibodies against all conceivable antigens and contact with the antigen in the postnatal period triggers the production of antibodies. It is postulated, however, that contact of an antigen with an immunologically competent cell in the prenatal period causes inhibition of the development of this clone so that all cells capable of forming auto-antibodies are eliminated by contact with "self" antigens in embryological life. These families of cells capable of producing antibodies against "self" are called forbidden clones.

The production of new clones of cells cannot be continued in postnatal life because forbidden clones might be created accidentally. Theoretically, the whole process should take place in some sequestered location where the information is stored and from which it is disseminated throughout the body, after which the central registry is eliminated. At once the parallel between this process and the history of the thymus is evident. The thymus is largest at the period of immunological deficiency early in life, but appears to be isolated from the body in the postnatal period. The lymphoid follicles in

the thymus have no germinal centers and thus are not immunologically active in the postnatal period, and both the follicles and the thymus itself atrophy with age. Although the thymus is rich in lymphoid cells and fails to produce antibody after systemic antigenic stimulation, direct injection of antigens into the thymus produces histological changes in its lymphoid follicles that are usually associated with the process of antibody formation, that is, the development of germinal centers. Thus, in the postnatal period it appears that the thymus is isolated from the rest of the body and that a blood-thymic barrier exists.

Changes in the thymus have been associated with several diseases. A few cases of thymoma with acquired agammaglobulinemia have been reported and an atrophic thymus has been found in cases of congenital agammaglobulinemia. Congenital alymphocytosis in infants is characterized by emaciation, repeated infections, underdevelopment of the spleen and lymph nodes, absence of gamma globulin, and an atrophic thymus gland. In AKR mice, a strain that is very prone to develop leukemia, thymectomy before six weeks of age results in a greatly reduced incidence of leukemia, but a subsequent thymic graft restores the incidence of leukemia to its previous high level. Similarly, thymectomy reduces the incidence of radiation-induced lymphomas in mice, while thymic grafting restores the potentiality for the development of lymphoma. Occasionally thrombocytopenia or granulocytopenia has been observed in an individual with an atrophic thymus. Auto-immune hemolytic anemia of an acquired type, several cases of which have been reported in humans, occurs spontaneously in a certain strain of mice. At three to 12 months of age, hemolytic anemia with a positive Coombs' test develops and the disturbance can be transmitted by injection of spleen cells. The thymus in these mice shows germinal centers and plasma cells, that is, there is evidence of antibody production in the thymus, and thymectomy prevents the development of the hemolytic state.

With all this evidence that the thymus is intimately involved in the immune response of the body, the relation between the thymus and another mysterious disease, myasthenia gravis, becomes even more fascinating. The pathological changes in myasthenic muscles consist of focal areas of decreased density of the end-plate sarcolemma within the secondary synaptic clefts, abnormal branching of the motor nerve terminals, and occasionally acute coagulation necrosis of the muscle. Of particular interest are accumulations of lymphocytes, or lymphorrhages, particularly in the perivascular areas of the muscles. In view of this, the thymic changes are especially pertinent. While a thymoma is found in about 15 percent of the cases, even more important is the high incidence of germinal centers within the lymphoid follicles of grossly normal thymus glands.

The evidence for an immunological abnormality in myasthenia gravis is strong. First, signs of inflammatory process frequently occur, such as an increased sedimentation rate and low grade fever. Also, it has been found that tagged 7S gamma globulin from patients with myasthenia is bound to the myasthenic skeletal muscle, and furthermore this binding is associated with fixation of complement, an indication of an immunological antigen-antibody reaction. Finally, if gamma globulin from a myasthenic patient is injected into a normal individual it becomes bound to normal skeletal muscle. This is evidence, then, that the thymic lesions in myasthenia may represent an immune response to an antigen, and that the disturbance in myasthenia is an immunological rather than a chemical or humoral one.

Summary

Although the thymus has guarded its secret for centuries, it appears that some information regarding its function is available at last. At least in the experimental animal, a functioning thymus gland in the neonatal period is necessary for the development of the immune defense mechanisms of the body. Even in the adult the thymus plays a permissive role in the recovery of the defense mechanisms after injury. Atrophy of the thymus has been found in agammaglobulinemia, in alymphocytosis, and in acquired hemolytic anemia. Some abnormality of the thymus gland is usually present in cases of myasthenia gravis, and there is evidence that the disease is primarily an immunological disturbance. Perhaps just as the pituitary and hypothalamus are the master centers for the control of endocrine function, the thymus may be the master gland concerned with the control of the immune response.

Allan M. Lansing, M.D., Ph.D., F.R.C.S. (C)

ORGANIZATION SECTION



MAY LODGE at Jenny Wiley State Park will be the setting of the 14th Annual Interim Meeting April 23. The park, with its spacious accommodations and modern facilites, is noted for the beauty of its mountain scenery.

Interim Meeting Plans Complete; Good Attendance Anticipated

Final arrangements have now been completed for the 14th Annual Interm Meeting of KSMA on April 23 at Jenny Wiley State Park, Prestonsburg, according to George P. Archer, M.D., Prestonsburg, KSMA president.

"Indications are that we will have one of the best attended Interim meetings we have ever had," Doctor Archer said, adding that "We are pleased that so many Kentucky physicians are planning to take advantage of the opportunity to hear the five excellent speakers who will address the all-day session on Thursday."

Speakers for the day include: Daniel F. Hanley, M.D., Brunswick, Me., executive director of the Maine Medical Association; Ernest B. Howard, M.D., Chicago, assistant executive vice president of the AMA; Durward G. Hall, M.D., Springfield, Mo., U.S. congressman from Missouri's 7th District; Clarence N. Walker, Atlanta, Ga., executive staff representative of the Coca-Cola Company; and Nicholas Nyaradi, Ph.D., Peoria, Ill., director of the School of International Studies at Bradley University.

Entertainment for the attending physicians, their wives and guests, is planned for Wednesday evening, April 22, when the Patsy Teenagers, a widely traveled choral group from Prestonsburg, will present a varied musical program. The group performs under the direction of Mrs. Kathryn Frazier, who also acts as accompanist.

Registration for the meeting will begin at 8:45 a.m. April 23, at May Lodge at the Park. Doctor Archer will preside at the morning session. Delmas M. Clardy, M.D., Hopkinsville, KSMA president-elect, will preside in the afternoon.

Ky. M.D.s Urged to Participate In May 3-9 Immunization Week

Immunization Week, May 3 - 9, has been made official in Kentucky by proclamation of Governor Edward T. Breathitt, and the KSMA Committee on Public Health has completed plans for its observance.

The participation of all KSMA members is urged by committee chairman M.A. Shepherd, M.D., Somerset. Each physician can help, he said, by checking the immunization status of his patients and by displaying the special posters mailed from the AMA headquarters office.

The compulsory immunization law, which has now been in effect for two years, requires that a child be immunized against diphtheria, tetanus, poliomyelitis and pertussis within twelve months after birth. No child under eighteen years of age can enroll in elementary or secondary schools without the required immunization unless his religion forbids it or a physician states that such immunization would be injurious to the child's health.

The effect of proper immunization was realized last year when a vigorous poliomyelitis vaccine campaign resulted in a year free of new cases of poliomyelitis in Kentucky. Doctor Shepherd stated that immunization must be a year-round program and Immunization Week is a means of bringing this to the public's attention.

Several organizations work with KSMA during this annual drive, including the Woman's Auxiliary to KSMA.

KSMA Trustee District Meetings Scheduled

Most of the KSMA District Trustees have scheduled meetings or have held meetings during the current associational year.

Members of the districts to hold meetings will receive individual invitations approximately four weeks before their district meetings in order to allow for ample time to attend. Invitations will contain detailed information on arrangements for the meetings.

KSMA president George P. Archer, M.D., Prestonsburg, is scheduled to be on the programs of the following trustee district meetings:

April 7, Tuesday—13th District—Clyde C. Sparks, M.D., Trustee; meeting at Ashland .

May 5, Tuesday—11th District—Hubert C. Jones, M.D., Trustee; meeting at Richmond.

May 12, Tuesday—6th District—Rex E. Hayes, M.D., Trustee; meeting at Russellville.

May 13, Wednesday—Joint meeting of the 12th and 15th Districts—Thomas O. Meredith, M.D. (15th), Trustees; meeting at Somerset.

May 14, Thursday—4th District—Dixie E. Snider, M.D., Trustee; meeting at Bardstown.

May 21, Thursday — 7th District — Donald Chatham, M.D., Trustee; meeting at Shelbyville.

May 26, Tuesday—2nd District—Howell J. Davis, M.D., Trustee; meeting at Owensboro.

May 27, Wednesday—1st District—O. Leon Higdon, M.D., Trustee; meeting at Paducah.

May 28, Thursday—3rd District—Gabe A. Payne, Jr., M.D., Trustee; meeting at Hopkinsville.

June 4, Thursday—8th District—W. Donald Janney, M.D., Trustee; meeting at Covington.

At press time some of the trustees who had not definitely scheduled meetings were making tentative plans for a district session.

On March 10, President Archer addressed the meeting of the 10th District in Lexington. Douglas E. Scott, M.D., Trustee from that district, presided.

Dr. Scroggin on AMA Group

Frederick R. Scroggin, M.D., Dry Ridge, has been named by the Board of Trustees of the American Medical Association to serve on the newly named ad hoc Committee on Quackery. Doctor Scroggin, who is chairman of the KSMA Council on Legislative Activities for State Affairs, was notified of the appointment by F. J. L. Blasingame, M.D., the AMA's executive vice president.

Dr. Clay Named to Office

Herbert L. Clay, Jr., M.D., Louisville, associate clinical professor of medicine at the University of Louisville, has been made governor for Kentucky of the American College of Cardiology. Doctor Clay replaces the late Morris M. Weiss, Sr., M.D., Louisville.



A FLOATING REUNION is in store for Medical Alumni of ten graduating classes of the University of Louisville on Tuesday evening, September 29, during the 1964 KSMA Annual Meeting in Louisville. The alumni of the classes of 1914, 1919, 1924, 1929, 1934, 1939, 1944, 1949, 1954, and 1959 will gather on the levee for a four-hour cruise up the Ohio on the Belle of Louisville. All U. of L. Alumni and their wives are invited to join the cruise.

KSMA 1964 Annual Meeting Site Is Modern, Convenient, Large

The recently renovated, completely modern Convention Center (formerly the Armory) in Louisville will be used for the first time this year by the Kentucky State Medical Association for the scientific sessions of its 1964 Annual Meeting September 29—October 1.

The large, air-conditioned Convention Center, called one of the best facilities of its kind in the country, is located on West Walnut Street one block from the Kentucky Hotel, and has convenient parking areas, according to George P. Archer, M.D., Prestonsburg, KSMA president and chairman of the Council on Scientific Assembly.

The Kentucky will serve as headquarters for both the KSMA and the Women's Auxiliary to KSMA. All scientific general sessions, all 15 specialty group meetings, and both scientific and technical exhibits, will be housed in the Convention Center.

An excellent scientific program, to include presentations by outstanding guest speakers of the cooperating specialty groups, is being planned for the Annual Meeting this year, Doctor Archer said. A feature of the program will be a symposium on diabetes to be held on Thursday morning October 1.

The House of Delegates of KSMA is scheduled to hold its sessions in the Terrace Room of the Kentucky Hotel at 9 a.m. Monday, September 28, and Wednesday evening, September 30.

Medical alumni of the University of Louisville and Vanderbilt University are planning class reunions during the Annual Meeting week. U. of L. alumni will be treated to a floating get-together aboard the Belle of Louisville on Tuesday evening, September 29. The University of Kentucky College of Medicine is making plans for a social gathering at a time not yet scheduled. More information on arrangments for these functions and other activities of the Annual Meeting will be published as they are released.



Governor Breathitt



Doctor Gaines

KSMA Schedules First Congress On Mental Health for May 14

The First KSMA Congress on Mental Health will be held at the Kentucky Hotel, Louisville, on Thursday, May 14 in cooperation with the Kentucky Department of Mental Health and the Kentucky Psychiatric Association. Planned by the KSMA mental Health Committee under the direction of Frank M. Gaines, M.D., Louisville, chairman, the day-long Congress is scheduled to get underway at 9:30 a.m., eastern standard time, and adjourn at 3:30 p.m.

The purpose of the Congress is to report on the appropriations approved by the 87th Congress for comprehensive mental health studies and to establish guidelines that should be pursued in mental health planning in the months and years ahead. Non-medical personnel as well as physicians are invited to attend. The congress will be limited to the first 300 registrations received in the KSMA Headquarters Office.

Governor Edward T. Breathitt has been invited to speak at the Luncheon Session beginning at 12:30 p.m. The roster of distinguished speakers includes Hamilton F. Ford, M.D., Galveston, Texas, Chairman of the AMA Council on Mental Health and President of the Texas Association of Mental Health; and leaders in the mental health field from across the Commonwealth of Kentucky.

The afternoon session will be highlighted by discussion groups on thought-provoking topics and a summation of the meeting at 3:20 p.m. Presiding at the morning and luncheon sessions will be George P. Archer, M.D., Prestonsburg, KSMA president. Carlisle Morse, M.D., Louisville, KSMA Vice President (Central), will preside in the afternoon.

A Look at the Past and Future Of Mental Health Program

Increasing interest in mental health by professional and non-professional persons has culminated in a burst of activity within the last few years.

A Congress-sponsored commission on mental illness and health made a national study, which led to the publication of "Action for Mental Health." This in turn led to the Kennedy Administration-sponsored bill to encourage community action to build and operate mental health centers throughout the United States. The American Medical Association, the American Psychiatric Association, and many other organizations have taken an active part in planning and promoting this research and legistlation.

We have now reached an even more crucial stage in the process, whereby we must make regional and local plans as to how we can best use this enthusiasm to full advantage in Kentucky. Physicians in all branches of medicine will need to take a continuing leadership in providing services for their patients in the area of mental health. This is not an area restricted to psychiatrists. The help and advice of all physicians is needed.

FRANK M. GAINES, M.D.

REGISTRATION FORM

Kentucky Congress on Mental Health
(Congress will be limited to first 300 registrations received)

1. Please pre-register me for the Kentucky Congress on Mental Health, Thursday, May 14 at the Kentucky Hotel, Louisville.
2. My check is enclosed for _____ registrations at $1.50 each, which includes the luncheon.

NAME _____

ADDRESS _____

_____

CLIP AND MAIL TO: KENTUCKY STATE MEDICAL ASSOCIATION
3532 JANET AVENUE
LOUISVILLE, KENTUCKY 40205

Program

First Kentucky Congress on Mental Health

Morning Session

George P. Archer, M.D., Prestonsburg, President
Kentucky State Medical Association, Presiding

9:00 **Registration, Lobby, Kentucky Hotel**

9:30 **Introduction to Congress, Doctor Archer**
Invocation
Announcements, Frank M. Gaines, M.D., Louisville, Chairman, KSMA Committee on Mental Health

9:40 **"Planning for Community Mental Health in Kentucky"**
Howard Bost, Ph. D., Lexington, Chairman, Kentucky Mental Health Planning Commission

10:10 **"Physician Responsibility in Community Mental Health Programs"**
Harold Schupbach, M.D., Owensboro, Member, KSMA Committee on Mental Health

10:35 **Coffee Break**

10:50 **"Medical Leadership for State and Community Mental Health Programs"**
Hamilton F. Ford, M.D., Galveston, Texas, Chairman, American Medical Association Council on Mental Health

11:20 **"Meet the Experts" (Question-and-Answer Period)**
Hamilton Ford, M.D.; Howard Bost, Ph. D.; Harold Schupbach, M.D.; Edward Frank, M.D.; Harold McPheeters, M.D.; and Joseph B. Parker, Jr., M.D., Moderator.

Luncheon Session

Doctor Archer, Presiding

12:15 **"Mental Health in Kentucky—Past and Future"**
Edward T. Breathitt, Governor, Commonwealth of Kentucky

Afternoon Session

Carlisle Morse, M.D., Louisville, KSMA
Vice President (Central), Presiding

1:45 **"Kentucky Mental Health Manpower Commission—Another First"**
Mr. William J. McGlothlin, Louisville, Vice Chairman, Kentucky Manpower Commission

2:15 **Group Discussions**

3:20 **Summation** —Doctor Gaines

3:30 **Adjournment**



Doctor Archer



Mr. McGlothlin



Doctor Schupbach



Doctor Ford



Doctor Morse

College of Surgeons Meeting Program Plans Released

The 1964 annual meeting of the Kentucky Chapter of the American College of Surgeons will be held at a new site this year at Stouffer's Louisville Inn on April 24 and 25. The meeting dates coincide with the opening of the Spring Racing Meet at Churchill Downs.

Actual live laboratory demonstrations at the new University of Louisville Medical-Dental Research Building, live televised surgery at Louisville General Hospital, and a 'Problem Clinic' during which surgeons present problems to visiting speakers for review, will be among the features of the 1964 meeting.

A scientific program for operating room nurses will also highlight the program of this important meeting. The Kentucky Chapter, ACS, wishes to extend a cordial invitation to all KSMA members, interns, and residents to attend the meeting. No registration fee is required of guests.

Following is the complete program:

Friday Morning

Registration will begin at 8 a.m. in Ballroom B at Stouffer's Louisville Inn. At 9 a.m. the scientific program will start Robert Robertson, M.D., Paducah, presiding. The morning session will include: *"Role of Early Interbody Fusion in Fractures of the Cervical Spine"*—Charles B. Wilson, M.D., professor and chairman, department of Neurosurgy, University of Kentucky College of Medicine.

"Mammography—Its Application in Breast Pathology"—William T. Rumage, Jr., M.D., assistant professor of surgery at U. of L. and current president of the Kentucky Chapter of the ACS, Joan Hale, M.D., radiologist, Norton Memorial Infirmary, and Emiliano P. Quilala, M.D., resident in surgery at Norton Memorial Infirmary, all of Louisville.

Also on the Friday morning progrom will be: *"Experiences with Surgical Treatment of Aneurysms of Femoral and Popliteal Arteries"* — J. Herman Mahaffey, M.D., instructor insurgery at the University of Louisville; *"Simplified Treatment of Breast Cancers"*—George Crile, Jr., M.D., F.A.C.S., department of surgery, Cleveland Clinic, Cleveland, O.; *"Endometriosis"* Francis B. Carter, M. D., professor and chairman, department of obstetrics and gynecology, Duke University School of Medicine, Durham, N.Car.; *"Athletic Injuries,"* Thomas B. Quigley, M.D., F.A.C.S., assistant clinical professor of surgery (orthopedics), Harvard Medical School, Boston; and *"Injuries of the Bladder and Posterior Urethra,"* James H. DeWeerd, M.D., F.A.C.S., assistant administrator, American College of Surgeons, Chicago.

Following a fellowship luncheon, the department of surgery at the University of Louisville will present the afternoon program under the direction of Rudolf J. Noer, M.D., professor and chairman of the department. The afternoon program will be held at the Medical Center; those attending will be taken by bus from the Stouffer Inn to the Center at 1:45 p.m.

Research Demonstrations will begin at 2 p.m. at the Medical-Dental Research Building. Presentations will be made by the faculty of the department on *"Physiologic Responses to Experimental Atelectasis"* —Allan M. Lansing, M.D., associate professor; *"Tissue Temps in Inflammatory States"*—Norton G. Waterman, M.D., instructor in surgery; *"Acessory Myocardial Envelope for Cardiac Support"*—Walter I. Hume, Jr., M.D., assistant professor; and *"Parabiosis in Study of Tumor Immunity"*—William H. Marshall, M.D., assistant professor.

At 3 p.m. the meeting will move to the fourth floor conference room at Louisville General Hospital to hear the following presentations by staff members of the department of surgery: *"Surgery in the Ninth and Tenth Decades of Life"*—Doctor Marshall; *"New Trauma"*—James C. Drye, M.D., professor of surgery, and R. Arnold Griswold, M.D., professor of surgery.

Two papers will conclude the Friday afternoon scientific session. They are: *"Transaxillary Sympathectomy for Neuro-vascular Disorders of the Upper Extremity"*—Harold E. Kleinert, M.D., associate professor of surgery; and *"Uptake and Distribution of Anesthetic Agents"*—Eugene H. Conner, M.D., professor and chairman of the department of anesthesiology.

A cocktail party at 6 p.m. and dinner and dance beginning at 7:30 will complete the program for Friday.

Saturday Morning

Both scientific sessions scheduled for Saturday will take place at Stouffer's Louisville Inn, beginning at 9 a.m. Richard F. Grise, M.D., Bowling Green, Will preside over the first panel, *"Tumor Progress,"* to be discussed by Doctors Carter, Crile, Quigley and DeWeerd.

A Problem Clinic Panel, composed of Doctors Carter, Quigley and DeWeerd, will discuss case summaries, and x-rays provided by the audience. These must be given to the moderator prior to the clinic. Moderator for this panel and the business meeting to follow will be Doctor Rumage. At 12:30 the members will depart for Churchill Downs for lunch and an afternoon at the races.

A luncheon and meeting for operating room nurses will be held Friday, April 24. David W. Griffin, M.D., Louisville, will preside. The following speakers and discussions will be heard: *"Chemotherapy in Gynecology"*—Doctor Carter; *"New Developments in Trauma Cases"*—Doctor Quigley; and *"Problems in Total Removal of the Bladder"*—Doctor DeWeerd.

U.L. Alums Hold Regional Meet

Donn L. Smith, M.D., dean of the University of Louisville School of Medicine, was the principal speaker at the April 9 regional meeting of the Covington and Cincinnati area medical alumni of U. of L. at the Fort Mitchell Country Club. William J. Temple, M.D., Covington pediatrician, was in charge of the meeting. According to Walter S. Coe, M.D., president of the Medical Alumni Association, who also attended the dinner meeting, the Alumni Association anticipates holding other regional meetings over the state in the future.

in virtually all diarrheas...prompt symptomatic control

LOMOTIL®

TABLETS / LIQUID—Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Research in the Service of Medicine SEARLE



Frederick R. Scroggin, M.D., right, is shown receiving the 1963 Conservation Service Citation presented to him March 6 by the National Wildlife Federation in recognition of his services in the field of natural resources management. Awarding the plaque to Doctor Scroggin are J. C. Butcher, left, a NWF regional director from Parkersburg, W.Va., and Judge Louis D. McGregor, Flint, Mich., NWF president.

Dr. Scroggin Honored March 6 By Wildlife Federation

Fred R. Scroggin, M.D., Dry Ridge general practitioner, was one of five recipients of the 1963 Conservation Service Citations presented March 6 at the opening session of the National Wildlife Federation's annual meeting at the Stardust Hotel in Las Vegas, Nevada.

During the two day Las Vegas meeting Doctor Scroggin was also elected as Regional Director of Region Five of the National Wildlife Federation. Region Five consists of Kentucky, Tennessee, Missouri, and Arkansas.

The citations, in the form of plaques, are presented annually by the NWF for "outstanding and distinguished service in the field of natural resources management". Doctor Scroggin, a former president of the League of Kentucky Sportsmen, is a member of the Kentucky Fish and Wildlife Commission. He is chairman of the KSMA Council on Legislative Activities for State Affairs, and a member of the newly named ad hoc Committee on Quackery of the AMA.

Dr. Allen on Hospital Council

John M. Allen, M.D., Lexington, was appointed by Governor Edward T. Breathitt on February 20 as a member of the Kentucky Hospital Advisory Council, replacing William J. McGlothin, Lexington, whose term expired.

The University of Louisville Medical Alumni Association will meet during the November 16-19 session of the Southern Medical Association in Memphis. Details on this meeting will be published at a later date.



Doctor Petty



Doctor Nakamoto

KAGP Plans Outstanding Program For May 6-8 Annual Meeting

Top-ranked guest lecturers representing a wide variety of medical fields, will present papers before the Kentucky Academy of General Practice May 6-8 during the KAGP 1964 Annual Meeting to be held at the Kentucky Hotel in Louisville.

Registration for the meeting will begin at 7:30 a.m. on Wednesday morning, May 6. The Invocation will be delivered at 8:40 a.m. by the Rt. Rev. Msgr. Charles C. Boldrick, Holy Trinity Church, Louisville. Following the invocation, brief welcoming remarks will be made by KAGP president Harry U. Whayne, M.D., Murray; George P. Archer, M.D., Prestonsburg, KSMA president; and George A. Sehlinger, M.D., Louisville, President of the Jefferson County Medical Society.

Doctor Whayne will preside over the Wednesday scientific sessions, to include the following speakers and topics: *"Liver Function Tests"*—Harry N. Hoffmann, M.D., Rochester, Minn., section of gastroenterology, Mayo Clinic; *"Retrograde Percutaneous Angiography"*—Don W. Chapman, M.D., Houston, Tex., professor in cardiology, Baylor University College of Medicine; *"The Use of Dialysis in the Treatment of Acute and Chronic Renal Failure"*—Satoru Nakamoto, M.D., Cleveland, O., department of artificial organs, Cleveland Clinic Foundation.

Other Wednesday speakers and their presentations include: "Problems in Seizure Control," Robert D. Currier, M.D., Jackson, Miss., chief of the division of Neurology at the University of Mississippi. The afternoon session will open with a discussion by Doctor Chapman on *"New Advances in the Surgical Treatment of Coronary Artery Disease,"* to be followed by *"Commonly Encountered Mononeuropathies"* —Doctor Currier; *"The Differential Diagnosis of Jaundice"*—Doctor Hoffman; and *"Human Penal Homotransplantation from Living Donors and Cadavers"*—Doctor Nakamoto.

A cocktail party for members and their wives and guests will begin at 6 p.m., ending the day's session.

Registration for the Thursday sessions, presided over by E. C. Seeley, M.D., London, KAGP president-elect, will begin at 8 a.m., with the scientific program starting at 8:55 a.m.

Speakers and their presentations for Thursday follow: *"Common Anorectal Disturbances"*—Francis J. Burns, M.D., associate professor of clinical surgery

at St. Louis University School of Medicine; *"Diagnostic Procedures in Children with Heart Murmurs"*—Donald G. Ritter, M.D., Rochester, Minn., section of Pediatrics, Mayo Clinic; *"The Treatment of Enuresis in Children"*—S. Richard Muellner, M.D., clinical associate in urology at Harvard Medical School, Boston; and *"New Concepts in the Diagnosis and Treatment of Thyroiditis"*—Penn G. Skillern, M.D., endocrinology department, Cleveland Clinic.

The afternoon presentations will include: *"Recurrent Urinary Infections in Women"*—Doctor Muellner; *"Congenital Hearth Lesions Correctable by Surgery"*—Doctor Ritter; *"Polypoid Thomas of the Colon and Rectum"*—Doctor Burn; *"Present-Day Prenatal Care"*—John A. King, M.D., New Orleans, La., instructor in obstetrics and gynecology at Tulane University School of Medicine.

A cocktail party of 6 p.m. on Thursday will be followed by the annual dinner dance at 7 p.m. in the Terrace Room of the Kentucky Hotel. Installation of Officers and presentation of awards will take place at this time.

Registration for the half-day session on Friday, presided over by the new president-elect, will begin at 8 a.m. with the scientific session to open at 8:55.

The following papers will be presented on Friday: *"Therapeutic Misadventure"*—Charles S. Petty, M.D., Baltimore, Md., with the State of Maryland Department of Post Mortem Examiners; *"Radioiodine in the Diagnosis and Treatment of Hyperthyroidism"*—Doctor Skillern; *"Obstetrical Emergency Situations"*—Doctor King; and *"Sudden Unexpected Death"*—Doctor Perry.

The Board of Directors will meet at 11:30 a.m. on Friday. Scientific exhibits and sessions will close at 12:00 noon. The meeting is acceptable for ten accredited hours by the American Academy of General Practice.

Dr. Hester Featured Speaker At Ky. Ob-Gyn Meeting

Lawrence L. Hester, M.D., professor and chairman of the department of obstetrics and gynecology at the Medical College of South Carolina at Charleston, will be the featured guest speaker at the May 7-9 annual meeting of the Kentucky Obstetrical and Gynecological Society at Louisville.

Another expert appearing on the program with Doctor Hester will be Colonel William F. Peterson of the U.S. Air Force Hospital at Andrews Air Force Base, Maryland, who will discuss "Experiences with Sparteine Sulfate in Obstetrics".

Local authorities will also appear on the program of this important three-day scientific and business meeting at Stouffer's Louisville Inn. Douglas M. Haynes, M.D., Louisville, president of the society, released the following tentative program:

Thursday, May 7
Morning Session

9:00 **Registration and Visit Exhibits**
10:15 **Welcome and Announcements**
Douglas M. Haynes, M.D., president
10:20 *"Histogenesis of Endometrial Carcinoma"*
Laman A. Gray, M.D., Louisville
10:50 *"Oral Contraceptives: To Use or Not to Use"*
William C. Durham, M.D., Louisville
11:20 *"Induction of Labor"*
Lawrence L. Hester, M.D., Charleston, S. Car.
12:00 **Luncheon interval. Executive Committee Luncheon Meeting.**

Afternoon Session

2:00 **Winning Residents' Paper**
2:30 **W. O. Johnson Prize Paper**
(Prize offered by A. J. Whitehouse, M.D., Lexington.)
3:00 **Visit Exhibits**
3:40 *"Hazards of Spontaneous Uterine Rupture"*
William E. Pugh, M.D., Louisville
4:10 **Annual business meeting and election of officers**
6:30 **Reception and Cocktail Party, Sponsored by Louisville Ob-Gyn Society.**

Friday, May 8
Morning Session
Louisville General Hospital

8:00 **TV Wet Clinic**
10:00 **Coffee Break**
10:30 *"Placentology and the Obstetrician"*
Frank Falkner, M.D., Louisville
11:00 *"Sheehan's Syndrome"*
Beverly T. Towery, M.D., Louisville
11:30 Topic to be announced
William M. Christopherson, M.D., Louisville

Afternoon Session

2:00 *"Management of Abruptio Placentae"*
Lawrence L. Hester, M.D., Charleston, S. Car.
2:40 *"Experiences with Sparteine Sulfate in Obstetrics"*
Col. William F. Peterson, Andrews AFB, Md.
3:10 **Visit Exhibits**
3:45 **Panel Discussion—Question and Answer Session**
6:30 **Cocktails**
7:30 **Banquet and Installation of Officers.**

Saturday, May 9

9:30 **Maternal Mortality Committee of the Kentucky State Medical Association — Open Meeting**
12:00 **Adjournment**

Emergency Medical Units Shown

The 200-bed Emergency Training Prototype Hospital and special Civil Defense equipment were demonstrated in Louisville, Friday and Saturday, February 28-29 by the State Department of Health and Civil Defense Officials. Physicians from Jefferson and surrounding counties received special invitations to visit the display and become familiar with the emergency hospital. There are 28 such hospitals stored in various sections of the state.

The emergency hospital has previously been demonstrated in other Kentucky communities and is available for further demonstrations. Anyone interested in having the hospital displayed in their area should contact the KSMA Headquarters Office.

AMA Bylaws



Chapter VI. Meetings-Section 2. Registration (A) Members-Active Member's Section registration shall correspond with his specialty or General Practice status as designated by him for classification in the American Medical Association Directory. To be accepted for Section registration purposes, a member of a Section who desires to change his registration from one Section to another because of a change in his specialty, shall be required to inform AMA Headquarters by written notice of this intention at least *sixty* days in advance of the Annual Convention.

Chapter VII. Sections-Section 7. Participation in Business Only *active members* registered in accordance with Chapter VI, Section 2 (A) shall have the right to participate in the *business deliberation* of a section.

Please Note

An Active Physician Member may not *change his Section* registration for voting purposes from one Section to another Section, unless written notice of a change in his specialty has been given the AMA Headquarters at least 60 days in advance of the opening day of the Annual Convention.

Upon completion of an Active Member's Registration at the AMA Registration Desk, members registering in advance and members registering for the first time will not be permitted to switch from one Section registration to another Section registration during the entire period that the AMA Annual Convention is in session.

However, all members are encouraged to attend any and all of the Scientific Section programs. Such attendance has no direct connection with the Section in which an Active Member may wish to be qualified to vote.

TO ASSURE YOUR VALID REGISTRATION AT THE 113th ANNUAL CONVENTION FILL IN THE COUPON BELOW:

PLEASE RETURN TO: Circulation and Records Dept.
American Medical Association
535 North Dearborn Street, Chicago, Illinois 60610

Cut Here

For ADVANCE REGISTRATION of Physicians

This coupon must be returned before June 2, 1964 to receive your Advance Registration Identification Card for San Francisco. Your card will be sent to you on June 9 unless you request an earlier mailing date.

Name (Please Print)_____
(Each Physician Must Register In His Own Name)

Address_____
City State Zip Code

I am a Member of the AMA thru the_____ State Medical

Association or in the following government service:_____

In accordance with the AMA Bylaws, I hold active membership in the AMA and I wish to vote in the Scientific Section I have checked.

- ☐ Anesthesiology
- ☐ Dermatology
- ☐ Diseases of the Chest
- ☐ Experimental Medicine and Therapeutics
- ☐ Gastroenterology
- ☐ General Practice
- ☐ Internal Medicine
- ☐ Laryngology, Otology and Rhinology
- ☐ Military Medicine
- ☐ Nervous and Mental Diseases
- ☐ Obstetrics and Gynecology
- ☐ Ophthalmology
- ☐ Orthopedic Surgery
- ☐ Pathology and Physiology
- ☐ Pediatrics
- ☐ Physical Medicine
- ☐ Preventive Medicine
- ☐ Proctology
- ☐ Radiology
- ☐ Surgery, General
- ☐ Urology

(Only Active Members Will Be Permitted To Vote)

USANOL®

a new approach
for an old problem

URINARY TRACT PATHOGENS URINARY TRACT PATHOGENS

USANOL Tablets are a urinary antiseptic and antispasmodic that destroy most urinary tract pathogens including strains resistant to antibiotics and sulfonamides.

COMPOSITION:
Each tablet contains:
Methenamine mandelate ..... 3.75 grs.
Homatropine methylbromide ..... 1/200 gr.

AVAILABILITY:
Available in bottles of 100 and 500 tablets.

DOSAGE:
Usual dose is one to two tablets 3 to 4 times a day but can be increased if needed.

CONTRAINDICATIONS:
Contraindicated in renal insufficiency, and caution in patients with glaucoma because of homatropine methylbromides.

ANOTHER ESTABLISHED NEED PRODUCT

FTP **First Texas** *Pharmaceuticals, Inc.* DALLAS • ATLANTA
SINCE 1901

U. of L. Alumni Reunion Set For AMA Annual Meeting

Medical Alumni of the University of Louisville will have a dinner meeting at the Fairmont Hotel in San Francisco on Tuesday, June 23, during the 1964 annual meeting of the American Medical Association, according to Walter S. Coe, M.D., Louisville, U. of L. Medical Alumni president.

The U. of L. group will be the only alumni association meeting in the AMA headquarters hotel this year. The association owes this priviledge to Harry R. Walker, M.D., a U. of L. Alumnus and othopaedic surgeon now practicing in San Francisco. Doctor Walker made all arrangements.

Tickets for this affair may be purchased through Director of Alumni Relations Lester Shively at the University or at the registration desk of the AMA at the 1964 meeting. In addition to others attending the meeting with President Coe, Donn L. Smith, M.D., Dean ot the U. of L. Medical School, plans to attend. Wives are cordially invited.

Ky. Surgical Society Program To Feature Dr. Warren

Kenneth W. Warren, M.D., chairman of the department of general surgery at the Lahey Clinic in Boston, will be the featured guest speaker on the program of the Kentucky Surgical Society Annual Meeting to be held in cooperation with the department of surgery of Vanderbilt University at Nashville May 15 and 16.



Doctor Warren

Doctor Warren, who received his B.S. degree from Harvard University graduated from the Temple University School of Medicine in 1938. He has been a member of the staff of the Lahey Clinic since 1945. He is a member of the American Medical Association, a Fellow of the American College of Surgeons and the American Gastroenterological Association, and holds membership in a number of other medical organizations.

H. William Scott, Jr., M.D., professor and chairman of the department of surgery at Vanderbilt, will be in charge of the Friday, May 15 program, the details of which are not yet complete. Doctor Scott has planned a most interesting program to include operative clinics and the grand-round type of patient presentation in the morning, with open discussion by the physicians attending the meeting. That afternoon a series of scientific papers will be presented.

A cocktail party and dinner with entertainment will be held on Friday evening for Surgical Society Members, their wives and guests at the Dinkler Andrew Jackson Hotel, which will serve as headquarters for the meeting.

Delmas M. Clardy, M.D., Hopkinsville, Society president, will preside at the Saturday session, to be held at the Andrew Jackson Hotel, beginning at 8:45 a.m.

Following is a list of speakers and their topics, in order of appearance:

Coleman C. Johnston, M.D., Lexington, *"Eosinophilic Gastritis"*; C. Melvin Bernhard, M.D., Louisville, *"McWhorter Incision for Carcinoma of the Splenic Flexure of the Colon"*; George B. Sanders, M.D., Louisville, *"Simultaneous Appendectomy and Right Inguinal Hernioplasty, a Critical Survey"*; Frank C. Spencer, M.D., Lexington, *"Total Prosthetic Replacement of the Aortic Valve—Experiences with 15 Patients"*; Ben Eisman, M.D., and (by invitation) Benjamin F. Rush, M.D., Lexington, *"New Techniques in Operations Upon the Head and Neck"*.

At 10 a.m. Doctor Warren will present a discussion of *"Current Management of Tumors of the Pancreas."* After this, the following physicians will speak: Laman A. Gray, M.D., Louisville, *"The Diagnosis and Treatment of Endometrial Carcinoma"*; David A. Hull, M.D., Lexington, and Gordon L. Hyde, M.D., Lexington, *"Early Subfascial Ligation of Perforating Veins in the Treatment of Venous Insufficiency"*.

Other speakers and their topics at the Saturday morning session will be: Ben Eiseman, M.D., Lexington, and (by invitation) William G. Malette, M.D., Lexington, *"New Methods for Prolonged Peritoneal Dialysis in Chronic Renal Failure"*; Ben Eiseman, M.D., and (by invitation) Charles B. Wilson, M.D., Lexington *"Unrecognized Abdominal Pathology in Patients with Head Injuries"*.

A short business meeting, starting at 12 noon on Saturday will complete the program of the 1964 annual meeting.

Dr. Fishel to Head Department Of Microbiology at U. of L.

Charles W. Fishel, Ph.D., currently a member of the faculty of the University of Colorado School of Medicine at Denver, will take over July 1 as head of the department of Microbiology at the University of Louisville School of Medicine. He will succeed James A. Kennedy, M.D., who will remain as a professor of microbiology.

Doctor Fishel graduated from Montana State University and obtained his master's degree from that school. He received his doctorate from the University of Chicago and did further study at Stanford University under a U.S. Public Health Service fellowship.

An authority on immunology, Doctor Fishel has published many articles on the subject in scientific journals and textbooks.



HOW TO BE SURE
your young patients get the aspirin dosage you want them to have

The answer is Orange Flavored Bayer Aspirin for Children

The dosage is 1¼ grains per tablet. Mothers place such confidence in the Bayer name. And the new orange flavor is so fresh and smooth that children take it readily. (The grip-tight cap on the bottle helps keep them from taking it on their own.)

For professional samples, just write The Bayer Company, Dept.112, 1450 Broadway, New York 18, New York.




RECOGNIZE
THIS PATIENT?
"I don't sleep well . . . I dream a lot . . . wake up tired and irritable. I don't have any appetite . . . I'll never be cured."

When you recognize signs of depression and anxiety and associate them with an organic condition—add 'Deprol' to your therapy.

Typical conditions in which 'Deprol' should be considered for control of the associated depression and anxiety:

cardiovascular disorders ■ arthritis ■ cancer ■ menopause ■ alcoholism ■ obesity ■ asthma, hay fever and related allergies ■ chronic infectious diseases ■ dermatoses ■ G.I. disorders, and many other organic disturbances.

When you recognize depression and anxiety traceable to an emotionally charged situation with no somatic disorder—start the patient on 'Deprol'.

Typical situations in which 'Deprol' is indicated:

fear of cancer or other life-threatening disease ■ pre- and post-operative fears ■ postpartum despondency ■ family problems ■ death of a loved one ■ loss of work ■ retirement problems ■ financial worries, and many other stressful situations.

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

BRIEF SUMMARY: *Indications:* Depression, especially when accompanied by anxiety, tension, agitation, rumination or insomnia. *Side Effects:* Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, or to physicians upon request.*

USUAL ADULT DOSAGE: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

SUPPLIED: Light-pink, scored tablets. Bottles of 50.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-817

MEDICAL SCHOOL NEWS

U.L. Gets $50,000 From State For New Medical Facility

The Honorable Edward T. Breathitt, Governor of Kentucky, presented a check for $50,000 to U. of L. President Philip Davidson at a February 27 dinner on the Belknap campus, thereby setting in motion plans for the proposed new medical-dental instructional facilities at the University of Louisville.

The money, which comes from the State's capital fund, represents the State's part of the planning costs of the structure, to be located on Preston Street north of General Hospital. Governor Breathitt presented the check at a dinner held by the University for the chief executive and more than 100 State Legislators and their wives.

It is hoped that construction on the new building, which will cost an estimated 12 to 18 million dollars, will begin soon in order to replace the present inadequate medical and dental teaching facilities.

Faculty Changes at U. of L.

S. Spafford Ackerly, M.D., was appointed distinguished professor of psychiatry, and John J. Wernert, M.D., was named clinical instructor in psychiatry at the University of Louisville School of Medicine during a recent meeting of the U. of L. Board of Trustees.

The trustees also have approved the following promotions in the School of Medicine faculty: Thomas R. Marshall, M.D., to associate professor; Alfred O. Miller, M.D., to associate clinical professor, and Ahmad Hatam, MD., to assistant professor, all in the department of radiology.

Also receiving promotions were: Heinz Oppenheim, M.D., to associate professor of otolaryngology; A. B. Lovemen, M.D., clinical professor of dermatology in the department of medicine; S. H. Cheng, M.D., associate professor of medicine; L. T. Minish, M.D., associate clinical professor of medicine; and Frank J. Swartz, Ph.D., to associate professor of anatomy.

15 Faculty Members Named For U.K. Medical Center

The Board of Trustees of the University of Kentucky recently approved the appointment of 15 new faculty members to the staff of the College of Medicine.

Among those appointed were: Philip Crossen, M.D., assistant professor of obstetrics and gynecology, and physician in the University Health Service; Edwin P. Jenevein, Jr., M.D., assistant professor of pathology; Daniel W. Wingard, M.D., assistant professor of anesthesiology; and Wayne Gordon, M.D., associate professor of medicine, and assistant director of the University Health Service.

Duane Tweedale, M.D., Mary Frances James, M.S., and Irene Roeckel, M.D., also appointed as assistant professors of pathology. James H. Parrish was named assistant medical librarian in the Medical Center Library.

Others receiving appointments were: William Bates, Ph.D., adjunct professor, department of Behavioral Science; Ronald L. Sergent, M.D., instructor of clinical medicine; George E. Vaillant, M.D., instructor of clinical psychiatry; and Don C. Pearl, Jr., M.D., instructor of surgery.

Henryk Chlebus, M.D., Warsaw, Poland, will serve as a research associate and guest lecturer in the department of medicine until December 1964. Thomas C. Moore, M.D., has been named professor of clinical surgery. Michael L. Furcolow, M.D., new project coordinator of the Martin County Tuberculosis Eradication Project, was appointed professor of community medicine.

AOA Chapter Chartered at U.K.

Victor Johnson, M.D., director of the Mayo Foundation at Rochester, Minn., and National president of Alpha Omega Alpha, academic honorary medical fraternity, delivered the principal address at the chartering ceremonies of Beta chapter of AOA at the University Medical Center on April 6. Doctor Johnson also conducted the chartering ceremonies.

Kentuckiana Ileostomy Club Reports on Activities

Sometime ago a group of ileostomy patients gathered together and formed the first "Kentuckiana Ileostomy Club."

The purpose of this club is to obtain information, exchange ideas and to help others in the future. To visit new patients in the hospital, give them the courage to accept their operation and determination to face the future in what ever field they choose to follow.

In the past six months, club members have been visiting the hospitals and it is very rewarding to see the splendid results that have come from these visits.

The meeting place is the Study Room in the Methodist Evangelical Hospital, time 7:30 p.m. 4th Tuesday of each month.

We have our own paper—"Louisville Courage Journal" with which we try to keep every one informed of the activities of our club.

In the past we have had many splendid speakers from whom we have gathered much knowledge.

It is our hope that in the near future all ileostomy people in the Kentuckiana area will be club members. Many associate members, to whom we are very grateful, work with us.

In closing I would like to extend a cordial welcome to any one interested in this field.

For further information regarding the club, please contact Mrs. Anita Kotheimer 595-2139 Louisville, Kentucky.

Bill Riley, President
Patricia Kotheimer, Sec.
Edwin Kratz, Treasurer
Kentuckiana Ileostomy Club



The discharged mental patient... and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. 27:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

SK&F *Smith Kline & French Laboratories*

News Items

Walton M. Edwards, M.D., has become a full time member of the faculty of the University of Louisville School of Medicine. A 1937 graduate of Cornell University Medical College, he interned in Cornell hospitals before becoming a pediatric resident at Children's Hospital of Philadelphia. In 1963 Doctor Edwards retired with the rank of Colonel after 23 years with the U.S. Army Medical Corps.

John Albert Ritter, M.D., has begun practice in association with **William H. Potter, M.D.,** at the Daniel Boone Clinic in Harlan. A surgeon, Doctor Ritter is a 1948 graduate of the University of Illinois School of Medicine, and interned at the University of Illinois Hospitals for Research and Education. Doctor Ritter is a Diplomate of the American Board of Surgery, a Fellow of the American and International Colleges of Surgeons, and a member of the Trudeau Society.

Eli Khouri, Jr., M.D., has entered the practice of urology at Paducah, it was recently announced. Doctor Khouri, a 1955 graduate of the University of Louisville School of Medicine, interned and completed his residency requirements at the U. of L. Hospitals and at Brooke General Hospital. After six and a half years in the U.S. Army, Doctor Khouri was released from active service with the rank of Major.

Edward C. Krecker, M.D., Louisville, has opened an office for the general practice of medicine in that city as an associate of **W. W. Spalding, M.D.** A native of Louisville, Doctor Krecker graduated in 1962 from the University of Louisville School of Medicine and interned at Charleston Memorial Hospital in Charleston, W.Va.

Nicholas Z. Kafoglis, M.D., Lexington, is now at the University of Kentucky Medical Center, where he is chief resident in obstetrics and gynecology. A 1956 graduate of the University of Pennsylvania School of Medicine, Doctor Kafoglis interned at Ohio State University hospitals before becoming a resident at the University of Florida. He was formerly in general practice at Bowling Green.

Nicolo D. Andreula, M.D., has begun the practice of general medicine at New Haven, it was recently announced. Doctor Andreula, who received his M.D. in 1954 from the University of Bari, Italy, interned at research hospitals in Kansas City, Mo., and served his residency in U.S.A. hospitals. His previous practice has been in U.S. hospitals

William H. Hosbach, M.D., has entered into the practice of general surgery at Paducah, it was announced. A native of Waverly, Ky., Doctor Hosbach received his M.D. from St. Louis University, St. Louis, Mo., in 1956 and served both internship and residency at St. Louis University. While serving in the U.S. Navy, he held the rank of Lieutenant.

Luis E. Davila, M.D., Highland Heights, has become associated with **Donald Stevens, M.D.,** for the general practice of medicine. A native of Quito, Ecuador, Doctor Davila graduated in 1952 from the medical school of the Central University at Quito. His internship was completed at Mercy Hospital at Hamilton, O., and his residency at St. Thomas Hospital in Akron.

Robert B. Miller, M.D., has opened an office at Paducah, where he will limit his practice to orthopaedic surgery. A 1956 graduate of Vanderbilt University School of Medicine, Doctor Miller interned at the University of California at San Francisco, and completed his residency there. Doctor Miller served as a captain in the U.S. Air Force.

Gene W. Scott, M.D., has become associated with the Williamsburg Clinic at Williamsburg, where he will limit his practice to general medicine. Doctor Scott, who graduated from the University of Tennessee School of Medicine in 1962, completed his internship at John Gaston Hospital in Memphis. He is a native of Memphis.

Daniel Pickar, M.D., staff physician at Veterans Administration Hospital in Louisville, took over in March as commanding officer of the 5010th U.S. Army Hospital reserve unit in Louisville. Doctor Pickar, who has been associate commanding officer, succeeds **Asa Barnes, M.D.,** now in Beckley, W.Va., who is retiring from the reserves.

William A. Brodsky, M.D., professor of experimental medicine at the University of Louisville School of Medicine, was named as one of 80 "Distinguished Alumni" by Temple University, Philadelphia, in ceremonies there on March 3.

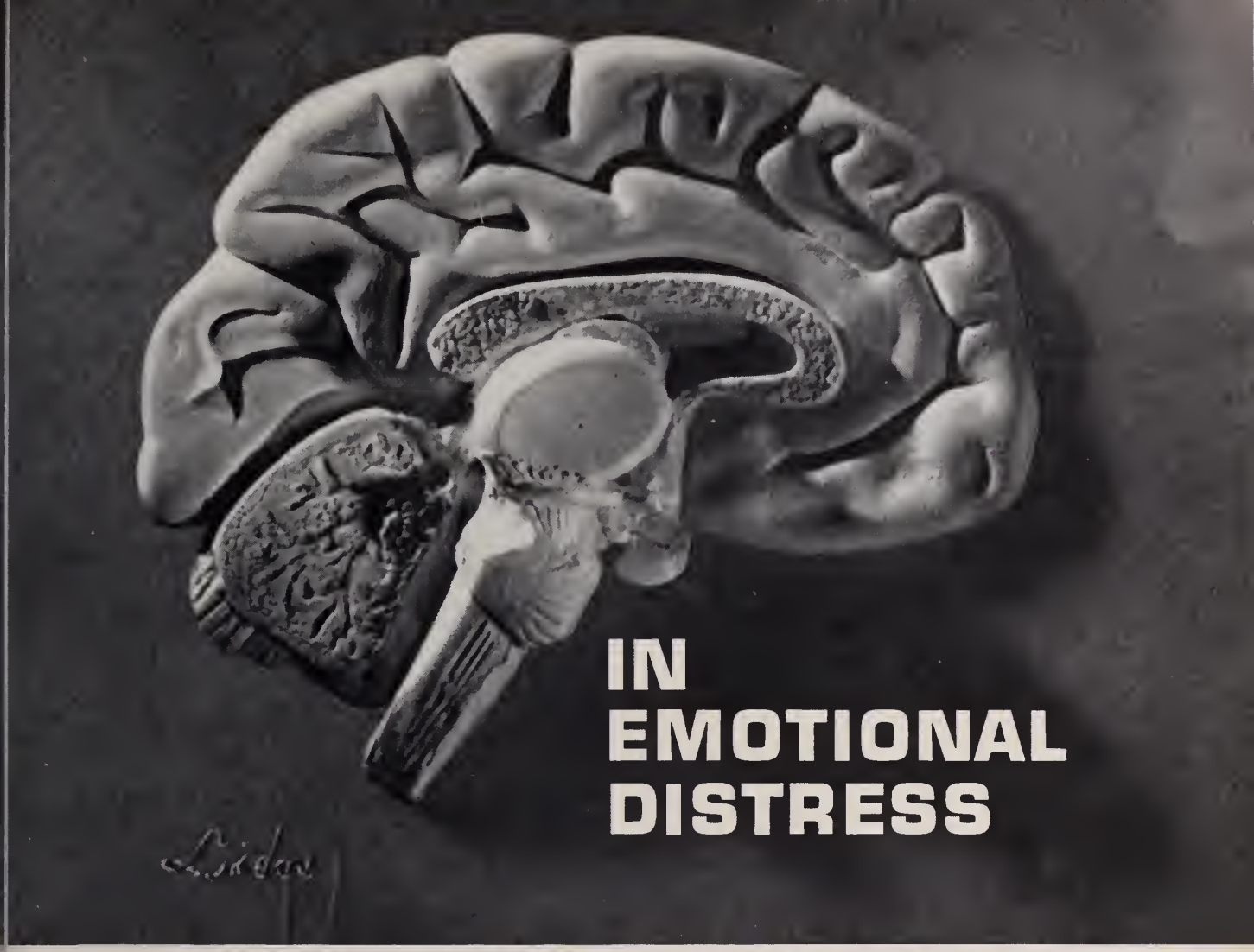
Murray M. Lipton, M.D., associate professor of microbiology at the University of Louisville School of Medicine, has been named by the American Board of Microbiology as a Diplomate in Public Health and Medical Laboratory Immunology.

Contribute to Medical Progress Through AMA-ARF Programs

When you contribute to the American Medical Association-Education Research Foundation, you are helping solve the problems to which you have dedicated your life.

Funds for medical schools and the Medical Education Loan Guarantee Program are major activities of AMA-ERF, but other significant projects are also supported including a program of training in medical journalism and—in the immediate future—funding of the Institute for Bio-medical Research.

Contributors to AMA-ERF can choose how their gift dollars shall be used. A contribution to any AMA-ERF project is tax deductible.



RELIEVES ANXIETY, APPREHENSION AND TENSION...



All day long

. . . keeps the patient calm, and the mind clear.



All night too

. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400

(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CME-1969

WALLACE LABORATORIES *Cranbury, N. J.*

In Memoriam

LOUIS Y. PESKOE, M.D.

Louisville, Ky.

1913 - 1964

Louis Yale Peskoe, M.D., 50, Louisville internist, died February 18 at his home. An associate professor of medicine at the University of Louisville School of Medicine, Doctor Peskoe graduated in 1937 from the University of Buffalo School of Medicine in Buffalo, New York. Doctor Peskoe, chief of gastroenterology at the Veterans Administration Hospital in Louisville, was a Fellow of the American College of Physicians, and a member of the AMA and other medical organizations.

Anderson Society Elects

Boyd Caudill, M.D., Lawrenceburg, was recently elected president of the Anderson County Medical Society. Other officers chosen for the coming year are George Gilbert, M.D., vice-president; R. N. Lawson, M.D., secretary-treasurer; Doctor Caudill, delegate to the KSMA; and Doctor Gilbert, alternate delegate. All the officers are from Lawrenceburg.

Boyd County Elects Officers

William F. Schnitzker, M.D., Ashland, has been chosen to serve as president of the Boyd County Medical Society for 1964. Other officers named were: Joseph S. Wheeler, M.D., vice president; Gerald B. Reams, M.D., Treasurer; and Charles A. Webb, M.D., secretary. Walter L. Cawood, M.D., was selected delegate to the Kentucky State Medical Association, with Guy C. Cunningham, M.D., chosen as alternate delegate. All are from Ashland.

Wholesale Drugs

and

Physicians Supplies

JOHN T. VIE CO., INC.

WH 4-7784 New Albany, Ind.

County Society Reports

McCracken

Barton McSwain, M.D., professor of surgery at Vanderbilt University, presented a paper on "Malignant Melanoma" at the January 29 meeting of the McCracken County Medical Society at Boswell's Restaurant in Paducah.

Following the scientific session, O.D. Maxey, M.D., president of the society, announced that the meeting of the Kentucky Academy of General Practice will be held in Paducah on July 30 at the Irvin Cobb Hotel.

Rex Holland, M.D. announced that a regional health clinic may be established at Paducah. Doctor Holland stated that before a regional mental clinic could be established, it would have to be endorsed locally by the County Medical Society. A motion was made and passed to endorse such a center, provided that there be some control over the staffing as to professional personnel by the County Medical Society, the Mental Health Commission, and the Kentucky State Board of Health.

Robert B. Miller, M.D., Claire B. Sledge, M.D., and William H. Hosbach, M.D., were recommended and approved for membership in the County Medical Society.

In conclusion, William B. Haley, M.D. announced the opening of the prototype 200-bed emergency hospital at the National Guard Armory in Paducah.

FOR SALE

Physician's waiting room furniture, consultation room equipment, and three treatment rooms fully equipped, all purchased in the last eight years.

Two-story brick veneer building, excellent physician's office on the first floor, modern attractive four-room apartment on the second floor, finished basement.

Stair glide purchased new, used only two months — bargain.

Write: J. O. Mattox, M.D.
903 Highland Avenue
Carrollton, Ky.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

(Research and Teaching Exhibits)

1964 Annual Meeting — Kentucky State Medical Association

Convention Center — **Louisville, Kentucky** — **Sept. 29, 30; Oct. 1**

Fill Out and Mail to:

BENJAMIN B. JACKSON, M.D., Chairman

Committee on Scientific Exhibits

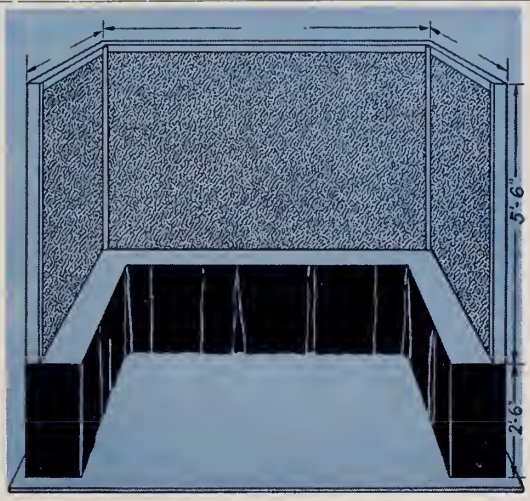
Kentucky State Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1964

Dimensions and structure of KSMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....

   .....

   Institution (if desired): .....

   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

   Charts and Posters.... Photographs.... Drawings.... X-rays....

   Specimens.... Moulages.... Other Material ..... (Describe)
6. Booth Requirements:

   Amount of wall space needed? .....

   Back wall ..... Side walls (All side walls are 4') .....

   Square feet needed? ..... Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

Signature of Applicant

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KSMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

APRIL

14-16	Kentucky Public Health Association, Kentucky Hotel, Louisville, Ky.
16	Diagnostic Problems in Disease of the Chest, Kentucky Thoracic Society, Kentucky State Dam Village, Ky.
17*	Electrocardiography Course, University of Kentucky, Lexington, Ky.
20	Southern Society of Clinical Surgeons, University of Kentucky Medical Center, Lexington, Ky.
21	Southern Society of Clinical Surgeons, University of Louisville, Louisville, Ky.
22	Southern Society of Clinical Surgeons, St. Joseph's Hospital, Lexington, Ky.
23	KSMA Interim Meeting, Jenny Wiley State Park, Prestonsburg, Ky.
23-24	TB, Fungus, Kentucky Thoracic Society, Rankin Amphitheatre & Louisville General Hospital, Louisville, Ky.
24*	Electrocardiography Course, University of Kentucky, Lexington, Ky.
24	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.
24-25	Kentucky Chapter, American College of Surgeons, Stouffers Inn, Louisville, Ky.
26	Kentucky Society of Anesthesiologists, Gabe's Restaurant, Owensboro, Ky.

MAY

1*	Electrocardiography Course, University of Kentucky, Lexington, Ky.
6-8	Kentucky Academy of General Practice, Kentucky Hotel, Louisville, Ky.
7-9	Kentucky Obstetrical & Gynecological Society, Stouffers Inn, Louisville, Ky.
8*	Electrocardiography Course, University of Kentucky, Lexington, Ky.
9-10	Ohio Valley Allergy Society, Stouffers Inn, Louisville, Ky.
12	KSMA 12th & 15th Trustee Districts Meeting, Somerset, Ky.
13	KSMA 6th Trustee District Meeting, Russellville, Ky.
13-14	Kentucky Pediatric Society, Medical Arts Building, Louisville, Ky.
14	Kentucky Mental Health Congress, Kentucky Hotel, Louisville, Ky.
14	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
14	KSMA 4th Trustee District Meeting, Bardstown, Ky.
15*	Electrocardiography Course, University of Kentucky, Lexington, Ky.
18-22	Refresher Course in Physiology for Practicing Physicians, University of Kentucky, Lexington, Ky.
21	University Surgery Day, University of Kentucky, Lexington, Ky.
22*	Electrocardiography Course, University of Kentucky, Lexington, Ky.
26	KSMA 2nd Trustee District Meeting, Owensboro, Ky.
27	KSMA 1st Trustee District Meeting, Paduach, Ky.
29	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.
29*	Electrocardiography Course, University of Kentucky, Lexington, Ky.

Surrounding States

APRIL

11-16	American Academy of General Practice, Atlantic City, N.J.
13-16	Industrial Medical Association, Pittsburgh, Pa.
16	2nd Annual Seminar on Premature Care, Good Samaritan Hospital, Cincinnati, Ohio.
18-19	Southeastern Dermatological Association, Medical College of Virginia Richmond, Va.
22	Non-Tuberculous Pulmonary Disease, Marion County General Hospital, Indianapolis, Ind.
29-May 3	Student AMA, Sherman House, Chicago, Ill.

MAY

1-2	Congress on Environmental Health Problems, AMA, Chicago, Ill.
4-8	American Psychiatric Association, Los Angeles, Calif.

* Electrocardiography course being held at U. of K. on consecutive Friday evenings will end May 29.

why does 150 mg.



do more than 250 mg.



of other tetracyclines?

Because it has up to 3½ times the *in vitro* antibacterial activity[1]...combined with lower rate of decay in serum, slower renal clearance...a favorable depot effect, resulting from protein binding...all providing rapid, higher and sustained *in vivo* activity with as much as 2 days' extra activity.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. **Side Effects** typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative *in vitro* Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

7516-3

Lederle

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem.

KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

Chatham CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey
Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

KSMA Council and Committee Reports

Council On Medical Education & Hospitals

Walter S. Coe, M.D., Louisville, Chairman

Louisville **February 20, 1964**

At its second meeting of this associational year, the Council on Medical Education and Hospitals approved a questionnaire on medical education and recommended to the Board of Trustees that this questionnaire be sent to all KSMA members. The council also reviewed a questionnaire which the General Practice Committee proposes to send out to a limited number of physicians.

The Chairman announced that the Board of Trustees had approved the council's recommendation to present the KSMA Scientific Achievement Award at the President's Luncheon during the Annual Meeting. It was also announced that the council had been given the responsibility of keeping informed on antivivisectionist legislation.

The council approved a recommendation from the advisory committees to Kentucky's two medical schools that the dues for full-time teaching and research members be 50% of the dues for regular, active KSMA members, and submitted this recommendation to the Board of Trustees. Similar action was taken on a statement submitted to the council concerning the objectives of a university hospital.

Joint Meeting of the Advisory Committees To the U. of L. and U. of K.

Andrew M. Moore, M.D., Lexington, Chairman, Adv. U of K

George A. Sehlinger, M.D., Louisville, Chairman, Adv. U of L

Louisville **February 6, 1964**

At a joint meeting, the Advisory Committees to the state's two medical schools recommended to the Board of Trustees that KSMA dues for full-time teaching and research members be 50% of the dues for regular active members. A statement of the objective of a university hospital was also submitted through the Council on Medical Education and Hospitals to the Board of Trustees for approval and distribution.

The two committees, in separate meetings, took action on recommendations submitted to the 1963 House of Delegates by the Council on Medical Education and Hospitals as pertains to the relationship of private practitioner and full-time faculty members.

Highway Safety Committee

Arthur H. Keeney, M.D., Louisville, Chairman

Louisville **January 30, 1964**

At the meeting of the Highway Safety Committee, a progress report on the Kentucky-Cornell Automotive Crash Injury Research Program was presented by ACIR representatives. This program, initiated August 1, 1962, has covered 594 accidents, injuring

1150 people, and killing 31, as of December 31, 1963. Sixty-six hospitals have cooperated in these Kentucky-Cornell studies, and the quality of both police and medical reporting has been excellent. The fourth phase began February 1, 1964, with thirteen new counties beginning a six-months' participation.

The program for Medical Aspects of Driver Limitation went into effect in Kentucky, January 1, and the first drivers are now pending study by the Medical Review Board. Both the Review and Appeals Board have been established to formulate opinions for the Division of Driver Licensing.

Commendation of this program by the *Virginia Medical Monthly* (*Virginia Medical Monthly*, V 90, page 611-18, December, 1963) and the American Medical Association House of Delegates (J.A.M.A. 187:376 (February 1), 1964) was acknowledged. A revised "Statement of Position" has been prepared for distribution the K.S.M.A. office in answer to numerous inquiries from out of the state.

The Kentucky Psychiatric Association and the Department of Mental Health each reported preliminary plans for the reporting of gross psychiatric limitation.

Contact Lens Course Set May 7

A one day program dealing with contact lenses will be presented at Louisville General Hospital on May 7 by the department of Ophthalmology of the University of Louisville School of Medicine. Roderick Macdonald, Jr., M.D., associate professor of ophthalmology at U. of L., will act as director of the program.

Speakers for the day will include: Jack Alexander, M.D., assistant Professor of ophthalmology at Indiana University; Chester Black, M.D., Elmhurst, Ill., and Walter R. Morris, M.D., instructor in ophthalmology at the University of Louisville. All ophthalmologists are invited to attend. For further information, please contact the department of Ophthalmology at U. of L.

Fulton Co. Officers Named

Andrew P. Nelson, M.D., Fulton, was named president, and Richard White, M.D., vice president, of the Fulton County Medical Society to serve for the coming year. Also elected were J. A. Poe, M.D., Fulton, secretary-treasurer; G. F. Bushart, M.D., Fulton, delegate to the KSMA; and John W. Ragsdale, M.D., Fulton, alternate delegate.

Scott Co. Society Elects

New officers of the Scott County Medical Society elected recently include Fred W. Wilt, M.D., president; James Campbell Cantrill, M.D., secretary-treasurer and delegate to the KSMA, and Hugh Smith, M.D., R. G. Wheeler, M.D., and H. G. Wells, M.D., members of the Board of Censors. All are from Georgetown.

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses

The one tranquilizer that

BELONGS IN EVERY PRACTICE

it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy.

Outstanding record of safety: Ten years of clinical use among millions of patients throughout the world—plus more than 1500 published reports covering the use of the drug in almost every field of medicine—support your prescriptions for 'Miltown' (meprobamate). This is why it *"belongs in every practice."*

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress—and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

Side effects: Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1 to 4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: 1 or 2 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. coated tablets.

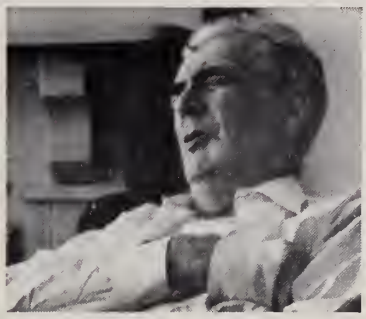
CM-1114



The insomniac



The tense, nervous patient



The heart-disease patient



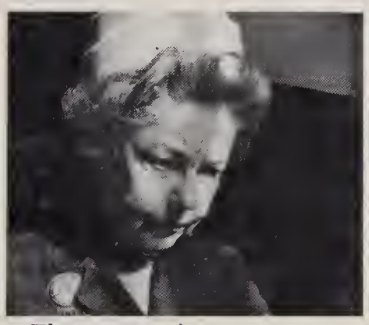
The surgical patient



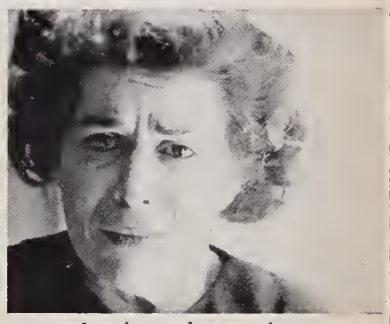
The girl with dermatosis



Tension headache



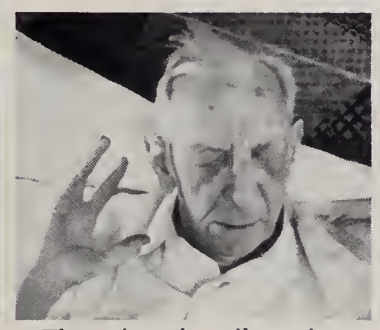
The woman in menopause



Anxious depression



Premenstrual tension



The agitated senile patient



The alcoholic



The problem child

the original brand of
meprobamate

Miltown®



The G.I. patient

WALLACE LABORATORIES
Cranbury, N.J.

IN THE BOOKS

SYNOPSIS OF EAR, NOSE AND THROAT DISEASES: by Robert E. Ryan, M.D., William C. Thornell, M.D., and Hans von Leden, M.D.; Published by The C. V. Mosby Co., St. Louis, 1963; 425 pages; Price $7.50.

Three prominent otolaryngologists, experienced in medical school teaching, have collaborated in the creation of an excellent synopsis of ear, nose and throat diseases.

To facilitate use of the synopsis the contents have been divided into four sections on a practical anatomical basis. Care has been taken that each author has written on the section of his special interest. This probably accounts for their original collaboration.

This synopsis fulfills a need as an excellent guide to all physicians treating ear, nose and throat diseases, teachers lecturing in otolaryngology, and ancillary to students using comprehensive textbooks.

George I. Uhde, M.D.

DISEASES OF THE CHEST: by H. Corwin Hinshaw, M.D., and L. Henry Garland, M.D.; Published by W. B. Saunders Co., Philadelphia, 1963; 798 pages; price, $20.00.

The strong points of this book are the abundance of well chosen chest x-rays, the excellent review and presentation of clinical pulmonary physiology in Chapter six, the coverage of the pneumonias, the section dealing with bronchiogenic carcinoma, and the four chapters devoted to tuberculosis. The excellent outline given at each chapter heading would be more useful if the page for each subject were also listed.

The places where the book seems most subject to criticism are a result of either omission of pertinent material or a failure to thoroughly revise some sections since the previous edition in 1956.

There is no discussion of the usefulness of the Cope needle in pleural biopsy. Electrocardiographic changes indicative of cor pulmonale are inadequately covered and there is not a single illustrative cardiogram to be found. An omission from the section on fluoroscopy is that of the recognition and importance of mediastinal flutter.

When one recalls that postoperative pulmonary complications occur in about 20% of those undergoing general surgical procedures, the section on treatment and especially the prevention of these complications is inadequate. The same may be said regarding acute respiratory acidosis, a frequently unrecognized and often fatal complication of obstructive airway disease.

The reviewer was also surprised to see the authors continue to perpetuate on pages 239 and 240 physical findings attributable to pulmonary emphysema by criteria which have been shown to lack specificity, are associated with aging, defy precise definition and possess a high degree of observer error. No reference was made to the outstanding work of Richard Ebert or Charles Fletcher in this regard.

These criticisms are rather minor, there are several others of a similar vein. This does not prevent the book from being strongly recommended to medical students and all physicians who encounter patients with diesease of the chest in their daily work.

William H. Anderson, M.D.

DISEASES OF THE SKIN FOR PRACTITIONERS AND STUDENTS: by George Clinton Andrews, M.D., and Anthony N. Domonkos, M.D.; Fifth Edition; Published by the W. B. Saunders Co., Philadelphia, 1963. 749 pages; Price, $16.50.

This book has an excellent index and nothing of importance has been omitted. It requires no effort to look up dermatological entities in either their proper or scientific names.

The photographic illustrations are superb and diagnoses are frequently possible from merely studying the prints.

The bibliography is arranged splendidly at the end of each chapter and is more than adequate.

The sub-specialties, including mycology, allergy and syphilis are handled briefly and yet with sufficient clarity to warrant no further lengthening of the material.

The Histopathology is discussed when indicated and is more than adequate and well illustrated. Therapy is discussed with each disorder and is very practical and up to date.

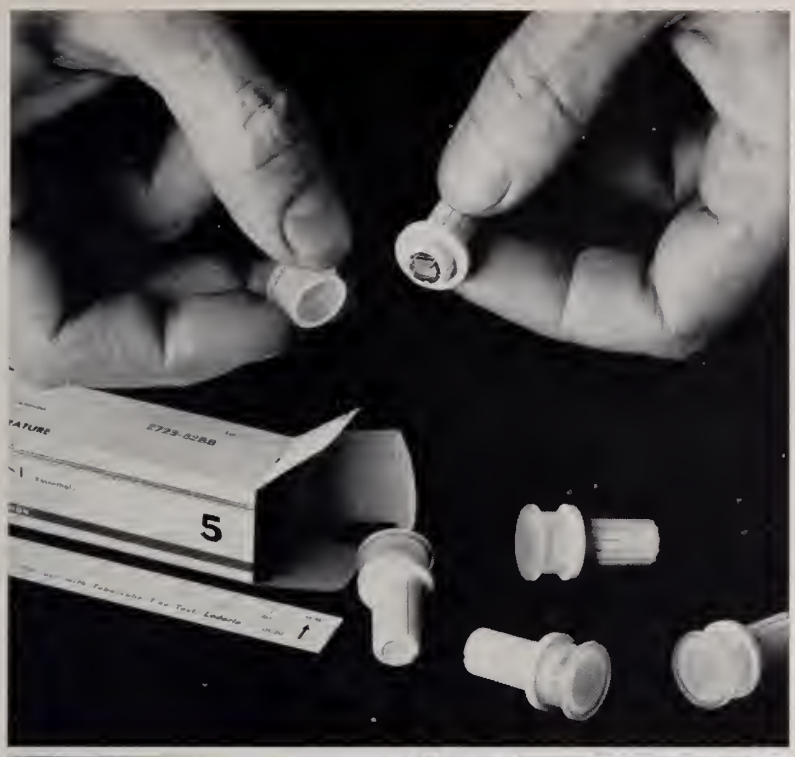
The text is not wordy. It is relatively concise for a textbook in dermatology (749 pages) and the style is such that it makes for enjoyable reading.

The publishers are to be complimented on the size of the book, the quality of the paper, the high calibre of the illustrations, as well as the size of the print, all of which make for easy reading and handling.

This book will take its place with previous editions by Doctor Andrews as one of the classics among dermatological texts. It is highly recommended to the student as an excellent, fairly concise and yet comprehensive textbook, and to the busy general practitioner who will find it most valuable as an aid in the diagnosis and management of the numerous cutaneous disorders he encounters in his practice.

It should be on every dermatologist's shelf serving as a ready reference book to him in his constant need for refreshing his memory on the numerous aspects of his chosen specialty.

A. B. Loveman, M.D.







TAKE 5

...and find that a TB screening test has never been quite so easy

SWAB THE ARM— UNCAP A TINE TEST— PRESS—DISCARD THAT'S ALL THERE IS TO IT.

Comparable to the Mantoux in accuracy and sensitivity, the TUBERCULIN, TINE TEST is now available in plastic-capped units uniquely suited to general practice needs. They are so simple to use that you can test every patient with ease. Since it requires no refrigeration, the new package of five Tine Test units can stand on any convenient table in your examining rooms, ready for routine use. Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis.

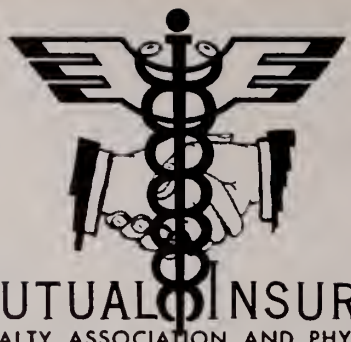
available as the new individually-capped unit, boxes of 5, or in cartons of 25

TUBERCULIN, TINE TEST

(Rosenthal) Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y. 7899-4

Lederle



PHYSICIANS MUTUAL INSURANCE COMPANY

(FORMERLY PHYSICIANS CASUALTY ASSOCIATION AND PHYSICIANS HEALTH ASSOCIATION)

115 SOUTH 42ND STREET OMAHA 31, NEBRASKA

Something "New" For Doctors

Protect Your Most Valuable Asset "Your Time"

Our New Sickness and Accident Protection Policy
Pays the Amount You Select up to $500.00 per Month
For Loss of Time Caused by Accident or Sickness

Insuring Physicians & Dentists for 60 years.

PHYSICIANS MUTUAL INSURANCE COMPANY

COUPON

Physicians Mutual Insurance Co.
115 So. 42nd St. Omaha 31, Nebraska
"Offering Protection to Physicians and Dentists Since 1902"

Name_____ Age_____

Address_____ City_____

test yourself

How much does the average American spend each year on these?

TOBACCO	ALCOHOL	R_X DRUGS
☐ $19	☐ $36	☐ $141
☐ $63	☐ $84	☐ $76
☐ $42	☐ $57	☐ $13





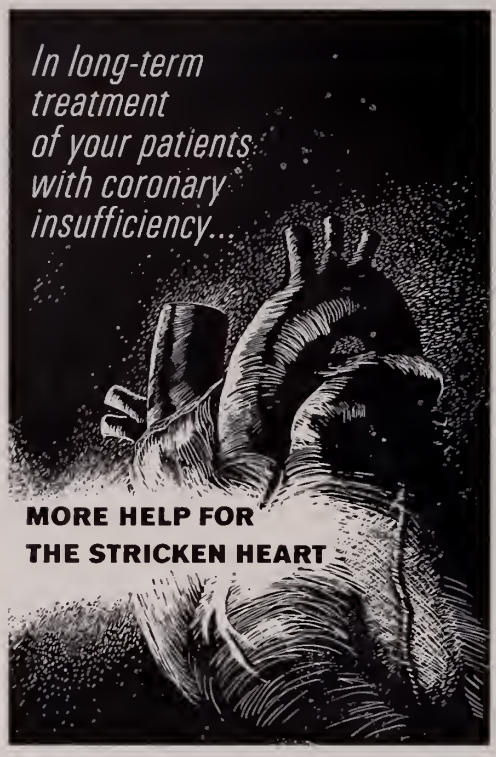


Score yourself 100% if you checked the bottom figure in each column. Yes, the U.S. Department of Commerce reports that 1962 per capita expenditure was $42 for tobacco, $57 for alcohol, only $13 for prescription drugs. That's about 25 cents per week per person for drugs that helped them stay well, get well, or possibly helped save their lives. Can you think of a bigger bargain?

Your patients might like to take this test, too. May we send you 25 copies for your waiting room?

Pharmaceutical Manufacturers Association — 1411 K Street, N.W., Washington, D.C. 20005

This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.



■ PETN (pentaerythritol tetranitrate) to increase oxygen supply

■ plus meprobamate to decrease anxiety and tension

Unlike phenobarbital, meprobamate is *not* cumulative and does *not* cause depression.

Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Precautions: Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Contraindications: Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* Dosage: 1 to 2 tablets, *before meals* and at bedtime. Individualization required. Supplied: Bottles of 50 tablets.

CML-1055

MILTRATE®

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

Allergists to Hold May Meeting

The Ohio Valley Allergy Society will hold its spring meeting May 9-10 at Stouffer's Louisville Inn. The meeting opens Saturday evening, May 9 at 7:00 p.m., eastern standard time, when William F. Mitchell, M.D., Columbus, Ohio, and Merles Scherr, M.D., Charleston, West Virginia, will appear on the program.

Sunday's session opens at 9:00 a.m. at Jewish Hospital and will conclude at 12:00 noon. Appearing on this portion of the program will be Jerry Cohn, M.D., Lexington; Allan Lansing, M.D., Louisville; and Daniel Stowens, M.D., Louisville. Complete information may be obtained by writing D. J. Parsons, M.D., Secretary, Ohio Valley Allergy Society, 1405 East High Street, Springfield, Ohio.

Ky. M.D.s on U.Va. Committee

Francis M. Massie, M.D., N. Lewis Bosworth, M.D., and William P. Wharton, M.D., all of Lexington, have been named members of the advisory committee of the University of Virginia Medical Alumni Association. The purpose of the recently organized committee will be to advise the medical school at the University in various fields.

WANTED

Full-time industrial physician for large plant of the Du Pont Company in Parkersburg, West Virginia—a growing industial area on the Ohio River. Salary Open. Permanent employment. Excellent opportunity. Please contact H. F. Gilbert, M. D., E. L. DuPont de Nemours & Company, P. O. Box 1217, Parkersburg, West Virginia. An Equal Opportunity Employer.

Madison, Indiana—WANTED: 2 General Physicians, July 1, 1964, in a fully accredited dynamically oriented Psychiatric Hospital. Minimum training—year internship. Citizenship and Indiana License required. Starting Salary $11,400. Complete family maintenance available at a very reasonable rate. Excellent opportunity for professional development in general medicine, neurology and psychiatry. Apply to: Ott B. McAtee, M.D., Superintendent, Madison State Hospital, Madison, Indiana.



THE INSURANCE PAGE



Extended Benefits Program Grows

IN 1961, following the recommendations of the K.S.M.A. Medical Advisory Commission to Blue Shield, the Blue Shield and Blue Cross Extended Benefit Endorsement was offered to eligible groups in Kentucky. Since enrollment in this plan has now grown to over 37,000 members and more firms are enrolling each month, it seems advisable to review the provisions of this growing service.

The following benefits are available to those members in groups who desire to purchase additional protection, provided underwriting requirements and enrollment percentages can be secured and maintained.

The purpose of the Extended Benefits Program is to provide long-term care for prolonged illness over and above regular Blue Cross-Blue Shield benefits. Maximum monthly group cost to an eligible individual is $1.10 and family $2.25. (This cost is in addition to the monthly dues for regular benefits.)

In-hospital benefits are: Up to 730 days.

Pays 80% of charges for private duty nursing under prevailing current fee and hour schedules for 30 days (1st day deductible).

Pays 80% of usual charges for X-ray therapy and surgical appliances.

Pays doctor's hospital visits $3.00 per day beginning 71st day.

Pays additional burgical benefits:

25% additional allowance on all procedures in the Preferred Schedule and Schedule D with an indemnity of $200 or more.

50% additional allowance on all procedures on the Standard Schedule and Schedule C with an indemnity allowance of $100 or more.

Following hospitalizations:

Pays for doctor's visits $4.00 per day except normal home or office postoperative care; Visiting nurse service $3.00 per day when prescribed by attending physician.

Pays 80% for necessary prescription medications.

Up to $8.00 per day in approved nursing home or convalescent hospital if admitted within 72 hours of discharge from a general hospital.

A member shall be entitled to receive 80% of charges in excess of the benefits provided by the basic certificate and endorsements thereto and in excess of $25.00 for each illness or injury, for X-ray examination, laboratory examination, physical therapy, X-ray and radiation therapy and electro-cardiograms performed in the out-patient department of a hospital, doctor's office, or laboratories referred by the physician. These benefits will be provided when rendered during the extended benefits period and when prescribed by the attending physician.

A member shall be entitled to physician's services for acute psychotic reaction, as:

a. Insulin shock therapy—$5.00 per sub-coma treatment; $8.00 per coma treatment, limited to a maximum of 70 insulin treatments;
b. Electric shock therapy—$12.00 per treatment, limited to 20 treatments;
c. Anesthesia—in connection with shock treatments, when performed as a professional service by a physician other than the attending physician, limited to $10.00 per treatment.

Limitations: Nervous and mental conditions, limited to 120 days. Excluded are pre-existing conditions for twelve months, maternity, sanitaria and rest cures, services provided by any other group coverage, and all exclusions in basic certificate unless specifically modified.

Lifetime maximum——$10,000.

Payments for eligible services rendered by physicians are made direct to the doctor. All groups enrolled in Extended Benefits have claim forms on file and a pamphlet describing how members are to file claims.

Important points to remember about Extended Benefits protection are that there is a twelve-month waiting period for pre-existing conditions; members are eligible for drugs, home and office calls only for those conditions for which they have been hospitalized; and there is a $25.00 deductible which must be satisfied for laboratory, X-ray, and physical therapy benefits. No allowance can be made for routine post-operative care. No claim can be paid unless properly signed by the doctor and the diagnosis is given. Descriptive literature and information on filing claims has been sent to all doctors in the new Blue Shield Participating Manual. W. VINSON PIERCE, M.D.



How to buy $15,852 for $37.50 a month

Unless you've begun to feel your age a bit, chances are you haven't given much thought to retirement plans. So you may be surprised to see how nicely a fund grows when you set up a plan to buy Savings Bonds and stick to it.

Let's say you decide to buy a $50 E Bond each month, cost $37.50. (An easy habit to get into on Payroll Savings because your employer saves the money for you *before* you get it.)

Keep it up for 17¾ years (E Bonds continue to earn 10 years beyond maturity) and you'll have Bonds worth $11,175. At this time you switch into H Bonds, adding enough to round out the total to $11,500. And during the next 10 years, you collect interest twice a year, mailed to your house.

Here's where you stand, 27¾ years after you signed that first Payroll Savings form. You own $11,500 worth of Bonds. You've collected interest checks of $4352.75. You've realized a total of $15,852.75 at a cost of $8312.50, a tidy reward for your efforts.

You'll also probably be warmed by the thought that all the time you were building your "escape fund," Uncle Sam was putting your dollars to work, helping keep the world as free for your golden years as it was during your younger ones.

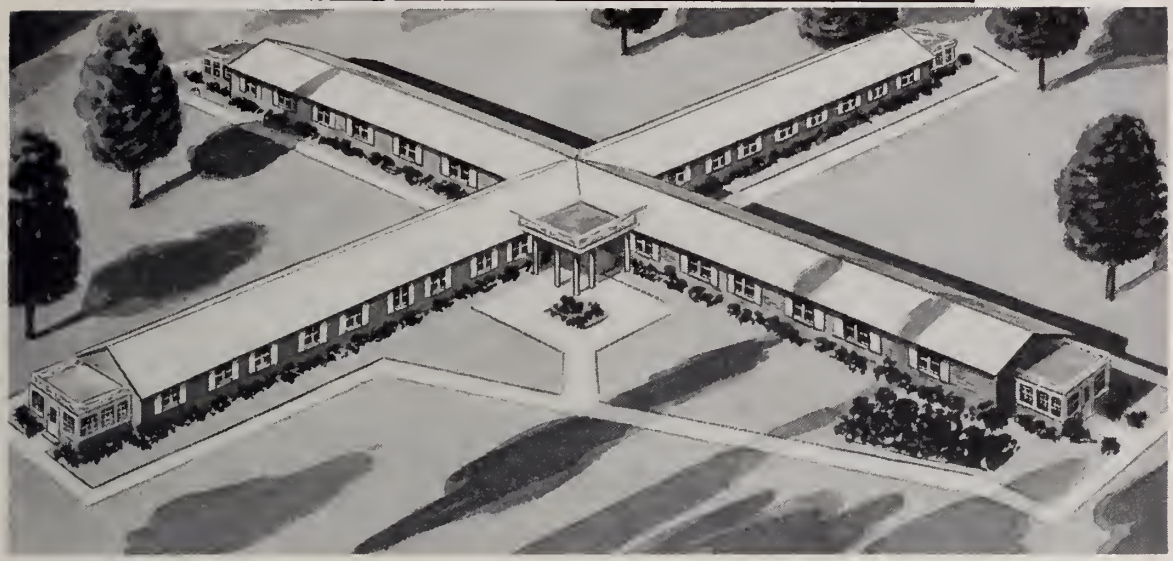
Worth thinking about, isn't it, whether you happen to be feeling your age or not.

Keep freedom in your future with

U.S. SAVINGS BONDS

This advertising is donated by The Advertising Council and this magazine.

MT. HOLLY
NURSING HOME



Somewhere to Live, Something to Do, Someone to Care

RESIDENTS

Provisions for geriatrics orthopedics and medical patients. Both young and old served on a short or long term basis

MOUNT HOLLY NURSING HOME
446 Mt. Holly Ave.
Louisville, Ky.
Phone: 897-1646

STAFF

Nursing Home Administrator
Michigan State University

Director of Nursing Services
Georgetown College and
Baptist Hospital.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
203 Parkside Building, 4140 Shelbyville Road, Louisville 7
Mailing Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884



Baker's L

VOL. 1 NO. 1 FORECAST: HAPPY MOTHERS AND BABIES

NEW 'UNDERC SOLVES DIAPI

Trio of suspects identified...

Bacteria a Prime Culprit Organisms such as Bacillus ammoniagenes and Alcaligenes faecalis metabolize urine into chemical irritants. Proper laundering of diapers helps reduce number of organisms, but cannot completely eliminate bacterial growth.

Ammonia and Urea Implicated Ammonia produced by microorganisms is a major cause of skin irritation that leads to diaper rash.

The Moisture—Maceration—Infection Cycle Moisture from urine and feces, combined with diaper friction, results in damp, macerated skin—an ideal environment for bacterial proliferation. In the absence of energetic countermeasures, the moisture—maceration—infection cycle continues, leads to chronic diaper rash problems.



aby News



BAKER LABORATORIES, INC.

OVER' AGENT R RASH CASE!

Diapersil successful!

Bactericidal to Ammonia-Splitting Pathogens Diapersil contains benzalkonium chloride, which is rapidly 'cidal' to organisms implicated in diaper rash. Benzalkonium chloride has a proven record of effectiveness and safety.

Continued 'Uripellent' Protection Silicones in Diapersil form a water-resistant coating which shields the skin from bacterial by-products and from maceration. Silicones have been found outstandingly effective in diaper rash, even when other types of therapy have failed.

Soothing to Inflamed Skin Panthenol, incorporated in a soothing and non-sensitizing base, relieves itching and pain, and gently promotes healing. Diapersil thus provides prompt symptomatic relief in diaper rash as well as in other pediatric skin conditions.

BAKER'S DIAPERSIL™ CREME

Formula: panthenol, dimethylpolysiloxane, benzalkonium chloride, in a watermiscible, non-sensitizing cream base

To treat and prevent diaper rash, excoriated buttocks, chafing, heat rash and similar conditions

BAKER LABORATORIES, INC. Subsidiary of U.S. Vitamin & Pharmaceutical Corp.

MURFREESBORO - VACANCIES:

STAFF PHYSICIANS for 1275 bed neuropsychiatric hospital, including 350 general medical and geriatric. Modern facilities for diagnosis and treatment of mental illness. Salary $11,150 to $18,405 depending on qualifications; fringe benefits; cost of moving to Murfreesboro will be paid by Veterans Administration; visit here for evaluation can be arranged at our expense. Excellent educational opportunities for students in this area. Contact Director, Veterans Administration Hospital, Murfreesboro, Tenn.

GET IN THE MIDDLE of THINGS . . .

Heyburn Building

The preferred professional address

A central location at the hub of public transportation; adequate nearby parking. Complete service with uniformed attendants.

All specialties are represented in The Heyburn Building. This has proven to be most helpful where consultation is indicated.

For information, contact:

DOWNTOWN LOUISVILLE MANAGEMENT, INC.
1401-A Heyburn Building 587-6982

McConnell on C. of C. Board

J. Ed McConnell, assistant executive director of Blue Shield and Blue Cross in Kentucky, has been elected as a new director for a three year term on the board of the Kentucky Chamber of Commerce.

Serving on the board is Gaithel L. Simpson, M.D., Greenville, recent past president of KSMA and chairman of the Governor's Advisory Council on Indigent Care.

Physician Needed For Mission

A physician interested in the diagnosis and treatment of a broad spectrum of disease in an area almost untouched by modern medical methods may take advantage of the opportunity offered by St. Mary's Mission, Ovemboland, South West Africa, to practice under the auspices of the Episcopal Church in this region for one year or more. Information on salary and expenses and other facets of the mission work may be obtained by writing to the Bishop of Damaraland, The Rt. Rev. Robert H. Mize, P.O. Box 57, Windhoek, South West Africa.

Mental Health Consultant Named

Donald L. Beckhart, Louisville, executive director of the Kentucky Commission on Aging since 1961, has been named rehabilitation consultant for the Kentucky Department of Mental Health. He will consult with the staffs of the Department's six hospitals about rehabilitation programs for patients. Beckhart, who received his BS degree from the University of Louisville in 1955, succeeds Stephen J. Cornett, Jr., who is now with the U.S. Department of Health, Education, and Welfare.

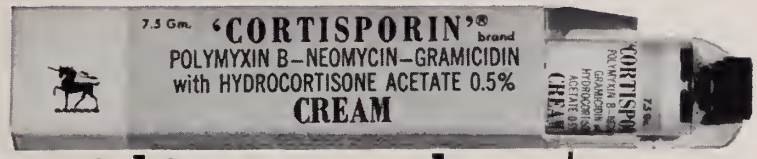
A. D. Butterworth, M.D., Murray, recently announced his resignation as health officer for Calloway County, due to ill health. Doctor Butterworth has served as health officer for Calloway, Graves, and Marshall Counties since 1960. Prior to that time he was in general practice in Murray.

C. F. Lewis, M.D., Jackson, was recently honored with a certificate and lapel button in recognition of his 15 years of service as Medical Advisor for the Selective Service System in Breathitt County. The award was presented on behalf of Lt. Colonel E. S. Stephenson, State Director of Selective Service.

Benjamin Felson, M.D., professor and chairman of the department of radiology at the University of Cincinnati College of Medicine, has accepted an invitation to serve as a national consultant to the Surgeon General of the U.S. Air Force, Major General R. L. Bohannon.

The advice to substitute the standard (drug) equivalent is based on the supposition that there is no difference —or even the possibility of a difference—between the branded product on which a reputable manufacturer has stakes his reputation and the anonymous substance dispensed by a chemist. This supposition is not supported by the facts, and could have serious consequences for doctor and patient alike.—*Medical News* (London), December 27, 1963.

CHOOSE THE PRODUCT TO FIT THE NEED



a new vanishing cream base



a special low melting point base

anti-inflammatory
bactericidal
antipruritic
rarely sensitizing

CREAM—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) 5.0 mg.; Gramicidin 0.25 mg.; Hydrocortisone Acetate 5.0 mg. (0.5%).

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, distilled water, and 0.25% methylparaben as preservative.

Available: In tubes of 7.5 Grams.

OINTMENT—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 500 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Hydrocortisone 10 mg. (1%).

In a special white petrolatum base.

Available: In tubes of ½ oz. and ⅛ oz.

*U.S. Patent Nos. 2,565,057–2,695,261

Indications: Wherever inflammation or infection occurs and is accessible for topical therapy.

Contraindications: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

Caution: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Dr. Ellison to Speak at U. L.

Edwin H. Ellison, M.D., professor and chairman of the department of surgery at Marquette University School of Medicine, Milwaukee, will be the guest speaker at noon April 22 at the 22nd annual Gross Lecture at the University of Louisville School of Medicine. The series is sponsored by Phi Chapter of Phi Delta Epsilon medical fraternity at U. of L. Co-sponsor this year is the department of surgery at U. of L.

Doctor Ellison will speak on "The Zollinger-Ellison Syndrome; A Study in Serendipity," at the Rankin Ampitheater at Louisville General Hospital. All interested physicians and students are invited to attend.

High school Juniors and Seniors interested in the sciences and engineering will once more be offered the opportunity to participate in the Junior Engineers' and Scientists' Summer Institute (JESSI) programs at colleges and universities all across the country. JESSI is a 13-day exporation and orientation session designed to give students an academic insight into pure and basic applied sciences and some knowledge of study programs and career opportunities in these fields. Kentucky students may be interested in these supervised programs at the University of Akron, Ohio, and DePauw University, Greencastle, Ind. For more information or application forms, contact Scientists of Tomorrow, 309 Fliedner Bldg., Portland, Ore., 97205.

V.A. Gives Emergency ID Cards

The Veterans Administration has started issuing the American Medical Association emergency medical identification card to selected veterans at its hospitals and outpatient clinics across the nation.

The VA said all its patients whose medical conditions carry special hazard, should they be rendered unconscious by accident or sudden illness, will receive the card. Among these may be epileptics, diabetics, those allergic to certain drugs or foods, contact lens wearers, and veterans taking certain medicines.

As an alumnus of the Food and Drug Administration, I have a friendly feeling toward that organization. Despite that I must oppose the unlimited power it is seeking over medical matters and matters of opinion. I cannot forget that the first chief of the Food and Drug Administration started out wrong on the toxicity of saccharin and benzoate of soda. His successors from top to bottom being mere mortals will inevitably be wrong many times again. The progress of medicine, the development of new and better tools for our physicians is a cause that makes it critically urgent that there be more ample opportunity for review by and appeal to others of decisions of this agency.—Theodore G. Klumpp, M.D., in *Journal of New Drugs*, July-August 1963.

* * *

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member Americon Hospital Association, Member Illinois Hospitol Assaciotion. Licensed by the Deportment of Public Health, State of Illinois.

The Modern Physician



must spend many hours keeping himself informed so that he may better serve his patients and his profession. Today, a doctor refers cases requiring special techniques to those trained in handling them. Just so, select your jeweler who must have training, experience and an established reputation for honesty and dependability. KENDRICK is such a jeweler, being a REGISTERED JEWELER of the AMERICAN GEM SOCIETY. Call on us at any time for expert advice and assistance in selecting quality gems. This service costs no more—in fact, you SAVE when you visit a reputable jeweler.

Kendrick
619 SO. FOURTH ST.



From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



CASE #153—A 28-year-old married white gravida 5 para 3, under the care of a private physician, had a calculated date of delivery of January 4, 1962. She was seen initially on the second month of pregnancy.

									1	2	3	4
Month:	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)		(9)		
BP		120	120	120	120	120	130	120				
		70	70	70	70	70	70	70				
Weight:		125	123	126	130	137½	139	143				
Urine:		neg.	neg.	neg.	neg.	neg.	neg.	neg.				
Hb. 11.5			VDRL non-deactive.									

The patient had a spontaneous abortion approximately seven months prior to the present pregnancy, followed by dilatation and curettage of the uterus. Following her last pregnancy three years before the current episode, she had suffered a postpartum hemorrhage necessitating emergency curettage.

The patient was admitted to the hospital at 7:00 P.M. on December 4, 1961 having moderately hard contractions at five minute intervals. On examination, the blood pressure was 120/80 and the fetal heart beat was counted at 140. The cervix was posterior, and on vaginal examination, no dilatation was detected. The presenting part was high. The patient continued to display moderately severe contractions during the evening and early morning hours; these were relieved by intramuscular administration of two 100 mg. doses of Demerol on two occasions. At approximately 5:30 P.M. on December 5, 1961, the patient began having harder contractions at three minute intervals. A 50 mg. dose of Demerol at 6:00 P.M. seemed to enhance the quality of the contractions, as did the spontaneous rupture of the membranes at 7:00 P.M.

At 8:00 P.M., the cervix was fully dilated, and the patient was taken to the delivery room. Under general anesthesia, a 6 lb. 6½ oz. living male infant was extracted from frank breech presentation without difficulty at 8:30 P.M. Following the delivery, there was an immediate gush of an estimated 500 cc of blood from the vagina. Initially, the bleeding was thought to be the result of premature separation of the placenta, a circumstance which could also account for the terminal rapid labor. The placenta was easily expressed after separation. An infusion of 1000 cc of 5% glucose in water with 2 cc of Syntocinon was started immediately and allowed to run as rapidly as possible. The uterus showed a contractile response and the bleeding diminished. No lacerations were seen on inspection of the cervix, and the upper and lower uterine segments were felt to be intact. The posterior wall of the uterus was roughened in consistency, but this finding was thought to represent normal contraction of the uterus.

The patient pulled the infusion needle out of her arm, and relaxation of the uterus followed, with prompt increase in bleeding. Blood was immediately ordered for transfusion, and a cutdown was performed in both legs. The cut down on the left side was unsatisfactory. Two units of plasma were rapidly pumped in as a temporary measure until the blood could be typed and cross-matched. The patient's blood type was AB positive, and no compatible blood was available in the hospital. After some delay, compatible blood was obtained, a cutdown was done in the left arm and a polyethylene tube was inserted so the blood could be rapidly given. In spite of constant manual massage of the uterus, it failed to contract. At this point, it was felt that the fundus should be re-explored to rule out a laceration not found initially. No definite tear or laceration could be detected. Another physician who was in the hospital examined the uterus and felt the previously noted rough area in the upper posterior wall of the fundus. Because of this finding and the patient's poor condition, it was felt that packing would not help, and that immediate exploration should be performed. Despite the fact that no blood pressure was obtainable and the pulse was very weak, laparotomy was done in the delivery room. Some extravasation of blood was found in the left adnexa. Hysterectomy was performed. Examination of the excised uterus disclosed an incomplete laceration of the posterior wall, in addition to some deep scars along the posterior wall that had apparently resulted from the previous surgery. The patient had by now exsanguinated and was pronounced dead at 10:30 P.M., approximately two hours postpartum.

The cause of death was listed as severe hemorrhage from ruptured uterus.

Comments

The Committee classified this case as a direct obstetric death with possible preventable factors. The laparotomy confirmed the suspicion of internal bleeding, and the cause of death was probably delayed in reexploring the patient in addition to the unavailability of the blood when needed. There may be justification in such emergencies to administer O negative, uncross-matched blood, despite the risk of hepatitis.

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS — 1963-1964

GEORGE P. ARCHER, Prestonsburg ..... President
DELMAS M. CLARDY, Hopkinsville ..... President-Elect
DAVID M. COX, Louisville ..... Immediate Past President
CARLISLE MORSE, Louisville ..... Vice President (Central)
CARL C. COOPER, Bedford ..... Vice President (Eastern)
JOHN DICKINSON, Glasgow ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, Corbin ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
DOUGLAS E. SCOTT, Lexington ..... Chairman of the Board of Trustees
GABE A. PAYNE, JR., Hopkinsville ..... Vice Chairman of the Board of Trustees

DELEGATES TO THE A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

BOARD OF TRUSTEES

First District ..... O. LEON HIGDON, Katterjohn Building, Paducah 1965
Second District ..... HOWELL J. DAVIS, 330½ Allen Street, Owensboro 1964
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville (serving interim term) 1964
Eighth District ..... DON JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1964
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1964
Eleventh District ..... HUBERT JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... CLYDE C. SPARKS, Mayo Arcade, Ashland 1964
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

BUYERS GUIDE

JOURNAL OF KENTUCKY STATE MEDICAL ASSOCIATION, APRIL, 1964

American Medical Assaciatian 306
Ames Company 339

Baker Labaratories 332-333
Burraughs Wellcame 26S-33S

Chatham Pharmaceutical, Inc. 320
Coca-Cola Company 270

Downtown Louisville (Heyburn Bldg.) 334
DuPant de Nemaurs & Company 328

First Texas Pharmaceuticals 307

Glenbraak Labaratories 309

Keeley Institute 336
Kendrick Jewelers 336

Lederle Labaratories 272-273-319-32S
Herbert Liebman 332
Eli Lilly Company 274

Madisan State Hasp. 328

J. O. Mattox, M.D. 316
Medical Protective Company 331
Mt. Hally Nursing Hame 331

New Castle Sanitarium 321

Parke, Davis & Company 260
Pharmaceutical Mfg. Co. 327
Physicians Mutual Insurance Company 326

A. H. Robins Company 267-268-269
Roche Laboratories 340

W. B. Saunders Company 261
G. D. Searle & Company 303
Smith Kline & French 313
Southern Optical 270

Veterans Administration 334

John T. Vie Company 316

Wallace Labaratories 271-310-311-31S-322-323-328
Winthrop Labaratories 263

neither **tension,** nor **spasm,**
nor **stasis**
stays this patient
from his
appointed rounds



DECHOLIN-BB®

. . . . . especially when
UPPER G.I. COMPLAINTS
have biliary implications

Each Tablet Contains:

for nervous **tension** → **BUTABARBITAL SODIUM** 15 mg (¼ gr.).
WARNING: May be habit forming

for smooth-muscle **spasm** → **BELLADONNA EXTRACT** 10 mg. (⅙ gr.).

for biliary/intestinal **stasis** → **DEHYDROCHOLIC ACID** 250 mg. (3¾ gr.).

Average adult dose: 1 or, if necessary, 2 tablets three times daily. **Precautions:** Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction; caution drivers against possible drowsiness. **Side effects:** Dehydrocholic acid may cause transitory diarrhea; belladonna may cause blurred vision and dry mouth. **Contraindications:** Biliary tract obstruction, acute hepatitis, glaucoma, prostatic hypertrophy. **Available:** DECHOLIN-BB, bottles of 100 tablets. **Also:** DECHOLIN® with Belladonna (dehydrocholic acid, 250 mg.; belladonna extract, 10 mg.) and DECHOLIN® (dehydrocholic acid, 250 mg.), bottles of 100 and 500 tablets.

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

349R263



New from Roche research

Valium®
(diazepam)

for
—situational, stress-induced tension
—the psychic tension of the common psychoneuroses
—emotional tension intensified by concomitant somatic components
also for
—the muscle spasms of cerebral palsy and athetosis

Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d.

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in dealing with psychotic patients manifesting anxiety and should be avoided when there is reason to believe the patient is psychotic.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.*, convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

How supplied: For oral administration: Valium (diazepam) scored tablets, 2 mg, white, bottles of 50 and 500; 5 mg, yellow, bottles of 50 and 500.

ROCHE LABORATORIES / Division of Hoffmann-La Roche Inc / Nutley, N. J. 07110

MAY 1964 VOLUME 62 NUMBER 5

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



LIBRARY OF THE COLLEGE OF PHYSICIANS
SEP 15 1965

In This Issue

Cutaneous and Mucous Membranous Clues to Some Systemic Diseases
Harold O. Perry, M.D. 359

Surgical Treatment of Heart Failure and Adams-Stokes Attacks
Frank C Spencer, M.D., Ben Eiseman, M.D., and J. T. Reeves, M.D. 365

'Hemotologic' Tumors of the Head and Neck
Giovanni Raccuglia, M.D. 369

Cancer of the Ovary—Need for Early Diagnosis
Allen E. Grimes, M.D., and Harold Redd, M.D. 372

Complete Contents on Page 344

KSMA Annual Meeting Sept. 29- Oct. 1
Convention Center, Louisville



if they can't see the woods for the pollen...

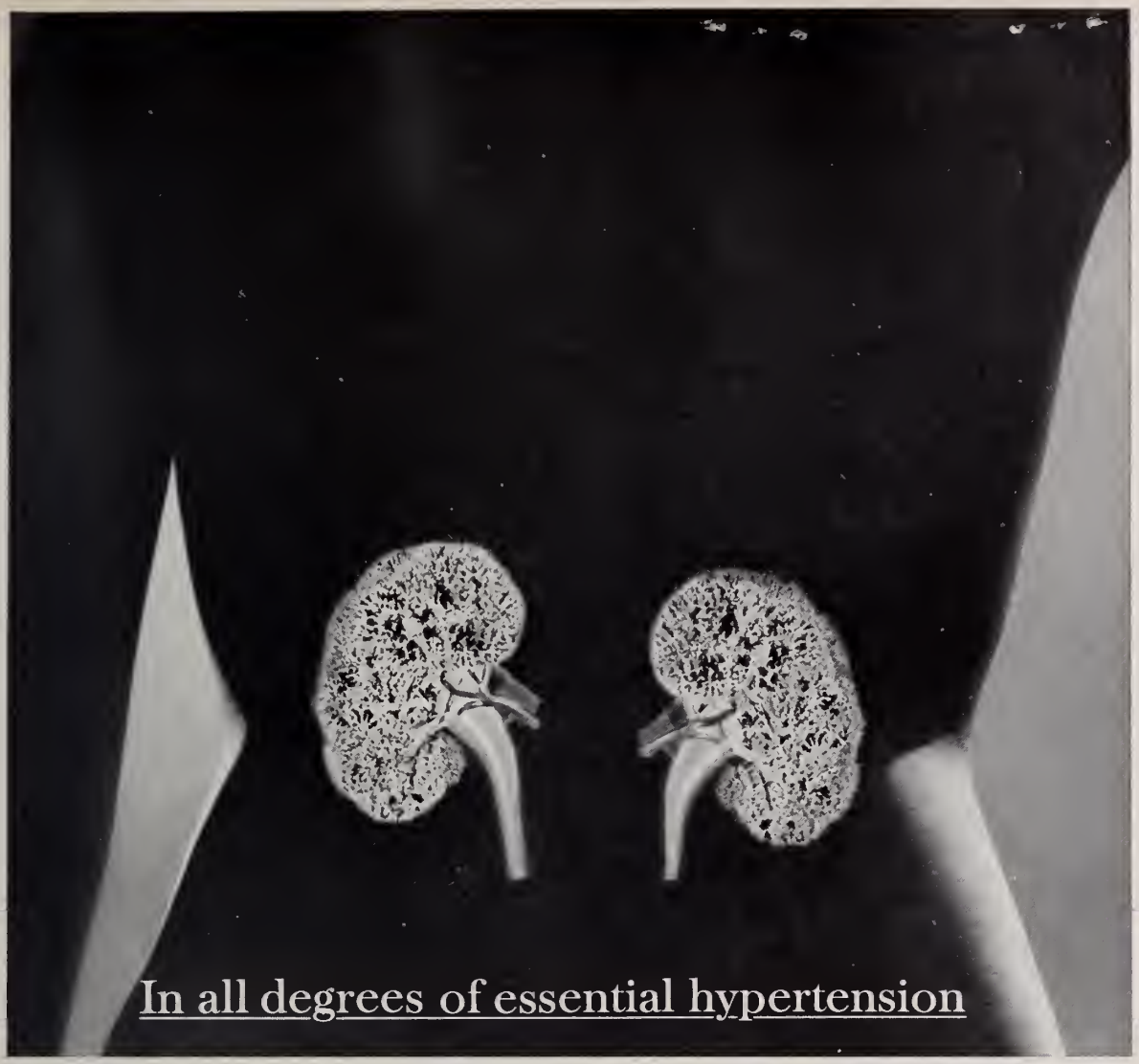
Benadryl®
(diphenhydramine hydrochloride)

PARKE-DAVIS

Throughout the pollen season this time-tested agent provides twofold action to relieve allergic symptoms. *Antihistaminic action* relieves nasal congestion, sneezing, lacrimation, and pruritus. *Antispasmodic action* relieves bronchial spasm. *Precautions:* Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers, if used with this product, should be prescribed with caution because of possible additive effect. Diphenhydramine hydrochloride has an atropine-like action which should be considered when prescribing it. BENADRYL (diphenhydramine hydrochloride) is supplied in several forms including Kapseals® containing 50 mg. 43364

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232



Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced.[1-2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality."[1] *Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients.* Rautrax-N is effective in mild,[3] moderate,[3,4] or severe hypertension.[4,5]

Dosage: Initially, 1 to 4 tablets daily preferably at mealtime. For maintenance, 1 or 2 tablets daily.

Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycosuria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin® [Rauwolfia serpentina whole root], 4 mg. Naturetin® [bendroflumethiazide], and 400 mg. potassium chloride. *Rautrax-N Modified*—50 mg. Raudixin [Rauwolfia serpentina whole root], 2 mg. Naturetin [bendroflumethiazide], and 400 mg. potassium chloride, in capsule-shaped tablets. For full information, see your Squibb Product Reference or Product Brief.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

SQUIBB
Squibb Quality
—the Priceless Ingredient
SQUIBB DIVISION Olin

RAUTRAX®-N RAUWOLFIA SERPENTINA WHOLE ROOT (50 MG.), BENDROFLUMETHIAZIDE (4 MG.) WITH POTASSIUM CHLORIDE (400 MG.), SQUIBB

VOLUME 62 • May 1964

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR

Sam A. Overstreet, M.D.

• ASSOCIATE EDITOR

Walter S. Coe, M.D.

• MANAGING EDITOR

J. P. Sanford

• ASST. MANAGING EDITOR

Ann M. Huntsman

• DEPARTMENTAL EDITORS

Jack L. Chumley, M.D., Scientific
Eugene H. Canner, M.D., Book Reviews
Oscar J. Hayes, Case Discussions
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR

George F. Brackman, M.D., Chairman
Willell H. Rush, M.D.
Blaine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Moore, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1966

Harold L. Bushey, M.D.
Edward J. Fadell, M.D.
Merle W. Fawler, Jr., M.D.
Joseph L. Goldstein, M.D.
John D. Lavell. M.D.
George F. McAuliffe, M.D.
Ralph G. Thomas, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965

McHenry S. Brewer, M.D.
Lewis Dickinson, M.D.
Zygmunt Gierlach, M.D.
Douglas L. Gillim, M.D.
Arthur H. Keeney, M.D.
James B. Stith, M.D.
Chester B. Theiss, M.D.
Kearns R. Thampson, M.D.

Term Expires July 1, 1964

Herbert L. Clay, Jr., M.D.
Orville T. Evans, M.D.
M. Randalph Gilliam, M.D.
John Gardinier, M.D.
Franklin B. Maasnick, M.D.
William Oldham, M.D.
Howard W. Ripy, M.D.
Samuel M. Smith, Jr., M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205

Subscription $8.00—single copy .80

Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

Cutaneous and Mucous Membranous Clues to Some Systemic Diseases
Harold O. Perry, M.D. 359

Surgical Treatment of Heart Failure and Adams-Stokes Attacks From Complete Heart Block with a Cardiac Pacemaker
Frank C. Spencer, M.D., Ben Eiseman, M.D., and J. T. Reeves, M.D. 365

"Hematologic" Tumors of the Head and Neck
Giovanni Raccuglia, M.D. 369

Cancer of the Ovary—The Need for Early Diagnosis
Allen E. Grimes, M.D., and Harold Redd, M.D. 372

CASE DISCUSSION

Eclampsia with Postpartum Psychosis 376

SPECIAL ARTICLE

International Community Medicine Clerkship 1963-64—Iran
Richard E. Geist 379

EDITORIALS

Kentucky Program on Medical Aspects of Driver Limitation 382

Charity Begins at Home 383

ORGANIZATION SECTION

Trans-Atlantic CPC Highlight of KSMA Annual Meeting 384
Preliminary Program Released for 1964 Annual Meeting 384
W. Leon Hisle Will Head Hospital Assn. in '65 385
Dr. Schuler Pres.-Elect of Ky. Dental Assn. 386
Dr. Brown Installed as Public Health Head 386
Five Kentucky M.D.s Appointed to AMA Committees 386
New U. of L. Microbiology Head to Assume Post July 1 388
Dr. Rash Marks 67 Years of Medical Practice 388
Louisville C. of C. Backs Plan to Form Area Hospital Council 390
Dr. Murray Receives Award As Outstanding Educator 390
Northern Ky. M.D.s Join in Annual Holy Week Retreat 390
1st KHA Community Service Award Given to KSMA Exec. Sec. 391

REGULAR FEATURES

President's Page 346
Public Health Page 354
Postgraduate Page 394
In The Books 400
Blue Shield Questions & Answers 411
Maternal Mortality Page 412

disability without debilitation . . .



supportive oral anabolic therapy • potent • well-tolerated

Disabling illness or injury at any time of life can invite a slowdown in the natural anabolic processes or acceleration of catabolic processes, resulting in a "wasting" of protein and minerals needed for tissue repair. Loss of weight and appetite, strength and vitality, may be the evident signs of this process, frequently accompanied by a lowering of mood, interest and activity. The older the patient, the more pronounced may be the signs of debilitation. A potent, well-tolerated anabolic agent plus a diet high in protein can make a remarkable difference.

WINSTROL® brand of STANOZOLOL

. . . a new oral anabolic agent, combines high anabolic activity with outstanding tolerance. Although its androgenic influence is extremely low*, women and children should be observed for signs of slight virilization (hirsutism, acne or voice change), and young women may experience milder or shorter menstrual periods. These effects are reversible when dosage is decreased or therapy discontinued. Patients with impaired cardiac or renal function should be observed because of the possibility of sodium and water retention. Liver function tests may reveal an increase in BSP retention, particularly in elderly patients, in which case therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage in adults, *usually 1 tablet t.i.d.;* young women, *1 tablet b.i.d.;* children (school age), *up to 1 tablet t.i.d.;* children (pre-school age), ½ *tablet b.i.d. Shows best results when administered with a high protein diet. Available as scored tablets of 2 mg. in bottles of 100.*

*The therapeutic value of anabolic agents depends on the ratio of anabolic potency to androgenic effect. This anabolic-androgenic activity ratio of Winstrol is greater than that of all the oral anabolic agents currently in use.

Winthrop

Winthrop Laboratories, New York, N. Y.



MESSAGE FROM THE PRESIDENT

Who Is Our Enemy?

THE real threats to the private practice of Medicine, under the free enterprise system, have their origin, not in the confines of socialism, but in the apathy and ignorance of those of us in the medical profession.

Organized Medicine, with all the tremendous work it is doing, is still sadly lacking in its ability to stimulate the average practicing physician into studying and working on the problems facing us.

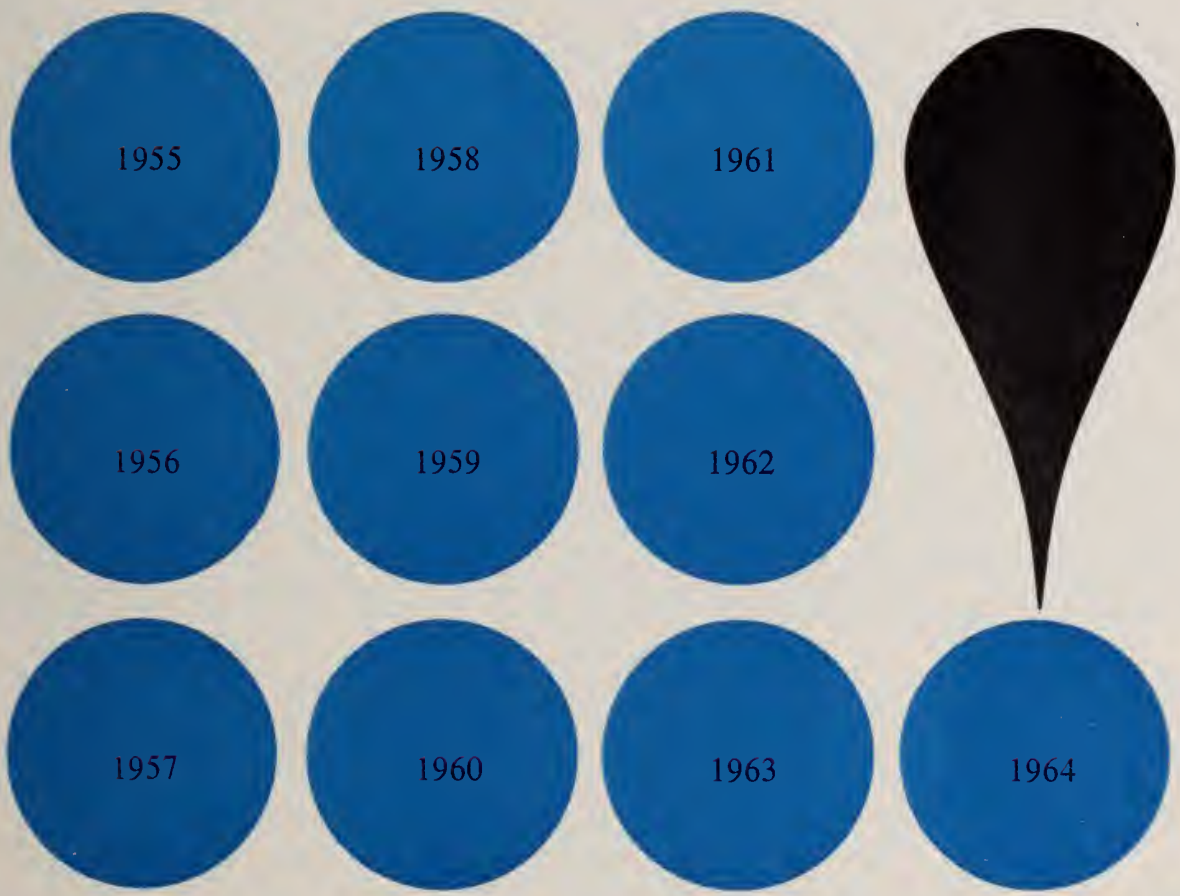
The foremost problem is how to reach the average physician who thinks he is too busy to "meddle" in politics. These are the individuals referred to as the "Free Riders" by Carlisle Morse, M.D., in the March President's Message. Payment of dues alone is not sufficient, we need action.

Unless the individual physician stops and thinks about the profession as a whole, and begins to do his part, we may soon find ourselves in a position from which we may not escape. God Forbid!

CARL C. COOPER, M.D.
Vice President (Eastern)

**This is the third in a series of guest articles written by the president of the Women's Auxiliary and the vice-presidents of KSMA at the request of KSMA president George P. Archer, M.D.*

The clear conclusion from 10 years' experience...



belongs in every practice

Miltown®
(meprobamate)

WALLACE LABORATORIES/Cranbury, N. J.

CM-2026



Accredited psychiatric hospital for private diagnosis and treatment

Approved by the Joint Commission of Accreditation of Hospitals.

Forty-acre estate to assure privacy in a restful environment.

Equipped to provide all modern and acceptable methods of treatment.

Ample classification facilities with qualified psychiatric nursing.

Full recreational therapy facilities.

CHARLES W. MOCKBEE, M.D.
Acting Medical Director

ISABELLE DAULTON, R.N.
Director of Nursing

GRACE SPINDLER, R.N.
Associate Director of Nursing

ELLIOTT OTTE
President and Chairman

CHARLES M. CLIFFE
Business Administrator

Brochure and rate schedule available on request

THE *Emerson A. North Hospital* INC.

(Founded 1874)

5642 HAMILTON AVENUE, CINCINNATI 24, OHIO • Telephones: 541-0135, 541-0136







TAKE 5

...and find that a TB screening test has never been quite so easy

SWAB THE ARM— UNCAP A TINE TEST— PRESS—DISCARD THAT'S ALL THERE IS TO IT.

Comparable to the Mantoux in accuracy and sensitivity, the TUBERCULIN, TINE TEST is now available in plastic-capped units uniquely suited to general practice needs. They are so simple to use that you can test every patient with ease. Since it requires no refrigeration, the new package of five Tine Test units can stand on any convenient table in your examining rooms, ready for routine use. Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis.

available as the new individually-capped unit, boxes of 5, or in cartons of 25

TUBERCULIN, TINE TEST

(Rosenthal) Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y. Lederle

7899-4

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

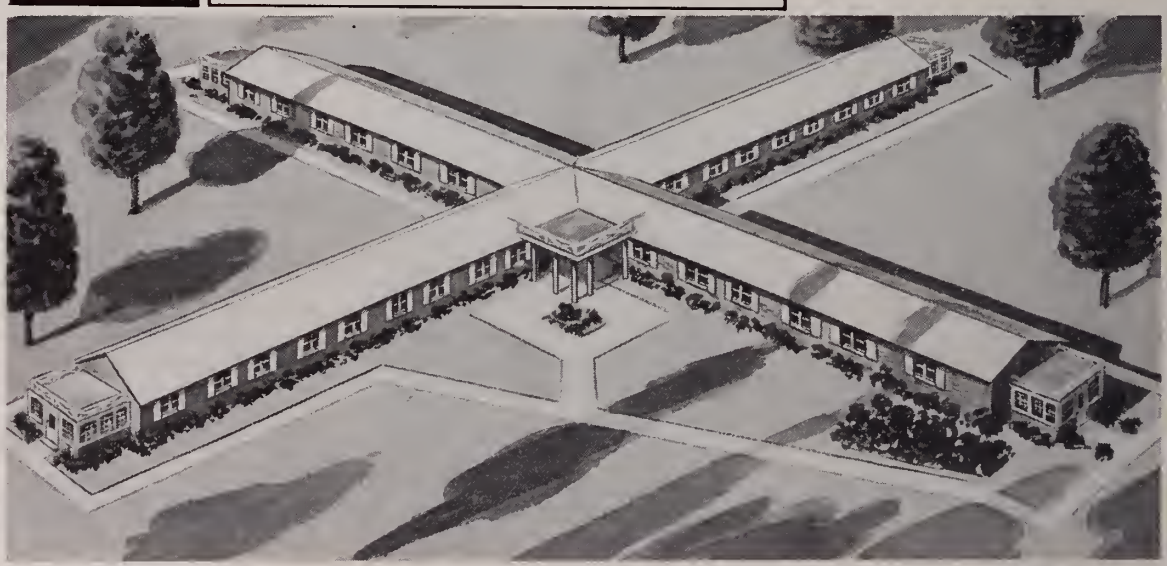
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lossiter, Representotive
203 Parkside Building, 4140 Shelbyville Road, Louisville 7
Moiling Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884

MT. HOLLY
NURSING HOME

A Nursing Home with Hospital Standards



RESIDENTS

- Geriatrics
- Orthopedics
- Medical

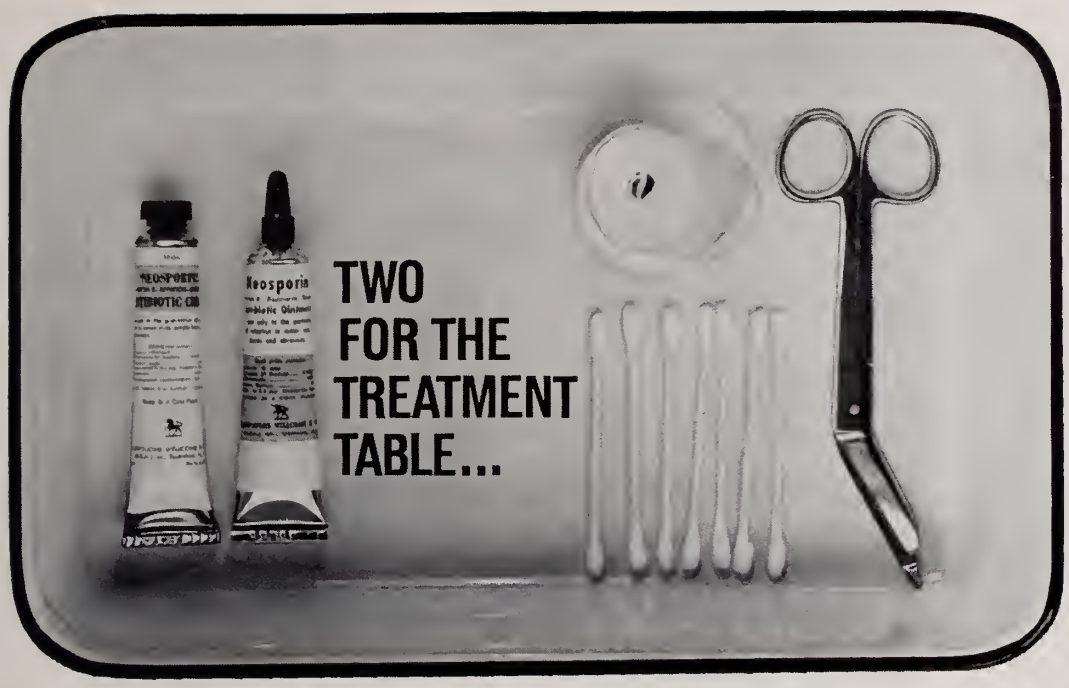
Young and Old served on a short or long term basis.

MOUNT HOLLY NURSING HOME
446 Mt. Holly, Ave. (off Brownsboro Rd.)
Louisville, Ky.
Phone: 897-1646

STAFF

Nursing Home Administrator
Michigan State University

Director of Nursing Services
Georgetown College and
Baptist Hospital.



Both the Cream and Ointment rarely sensitize and are bactericidal to virtually all gram-positive and gram-negative organisms found topically, including Pseudomonas aeruginosa and Staphylococcus aureus.

Indications: Wherever infection occurs and is accessible for topical therapy.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

'NEOSPORIN'® brand
POLYMYXIN B / NEOMYCIN / GRAMICIDIN
ANTIBIOTIC CREAM

Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Gramicidin 0.25 mg.

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, distilled water, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax and 0.25% methylparaben as preservative.

*U.S. Patent Nos. 2,565,057-2,695,261

Available: In 15 Gm. tubes.

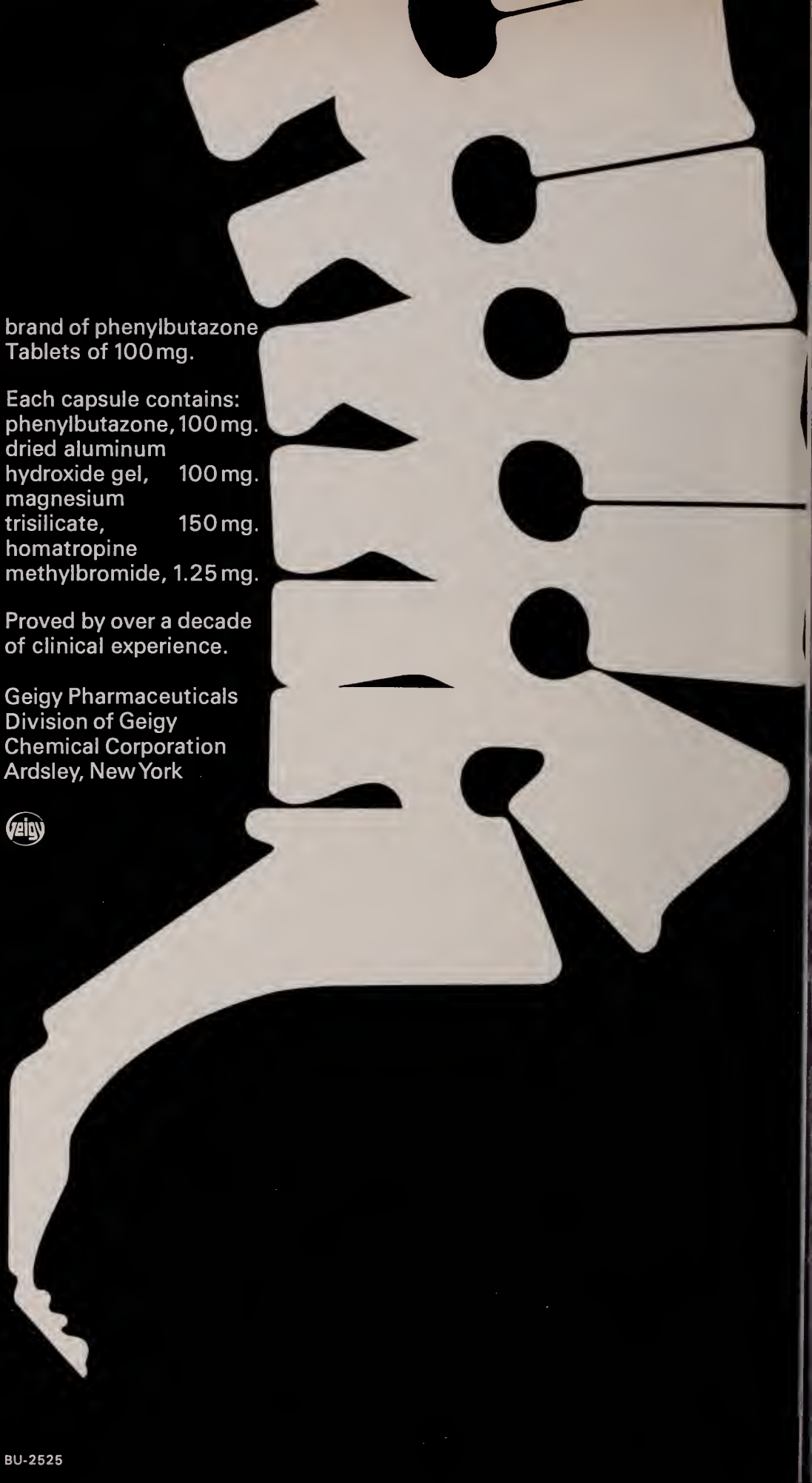
'NEOSPORIN'® brand
POLYMYXIN B / BACITRACIN / NEOMYCIN
ANTIBIOTIC OINTMENT

Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base).

Available: Tubes of 1 oz., ½ oz. and ⅛ oz.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Butazolidin®

brand of phenylbutazone
Tablets of 100 mg.

Butazolidin® alka

Each capsule contains:
phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

It works!

Proved by over a decade of clinical experience.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

BU-2525



release for hostility?

Overeating is often an outlet for feelings of hostility. Many people take out their anger by overindulgence at or between meals. As a result they become overweight.

'Eskatrol' *Spansule* capsules both control appetite and relieve the emotional stress that causes overeating. That's why so many patients are losing more pounds with 'Eskatrol'.

ESKATROL® Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

SPANSULE®

brand of sustained release capsules

because emotions play an important role in overweight

Brief Summary of Principal Side Effects and Cautions

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory. *Cautions:* 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

For complete prescribing information, please see *PDR* or available literature.

Supplied: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F

PUBLIC HEALTH PAGE

Importance of Emergency Vector Control*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health
Commonwealth of Kentucky

UNDER our high standards of living we are little concerned with epidemics of vector-borne diseases; however, this has not always been true. Throughout history epidemics of plague, malaria, and yellow fever, to mention a few, have taken untold millions of lives. Not only was there a lack of adequate treatment and prevention, but the theory of disease organisms; their propagation and spread had not beeen developed. Subsequently, the advancements by scientists, particularly in the fields of human and animal medicine, have solved many former disease problems. It is unfortunate, though, that formerly unknown problems related to health have arisen due to our scientific achievements.

Emergencies and disasters have occurred throughout the past and will probably continue in the future. Until recently most disasters have been due to forces of nature—floods, earthquakes, or hurricanes. With the development of modern warfare, especially nuclear, biological, and chemical devices, many may now create disasters of unknown magnitude. Modern warfare, like disease, is no respecter of persons or boundaries and may strike the most remote rural areas as well as metropolitan cities. All the technical and professional knowledge obtainable will be needed to cope with these devices. Health personnel, whether local, state, or federal, as well as those privately or institutionally employed, will be needed in controlling disease problems.

Natural disasters are usually of short duration and man's control over disease vectors is shortly re-established; however, this may be reversed in man-made disasters. In nature disease vectors occur in pockets or foci where conditions of environment are favorable for the continuation of the disease by maintaining a sufficient population of the vector as well as the host. Disasters can change these conditions permitting extension of these focal points into widespread epidemics.

After a nuclear disaster, the immediate problem of the individual will be survival by avoidance of radiation, caring for the wounded, and obtaining food and water. Later, procuring food and water will s take precedence; but if sanitation is left unheed formidable explosions in the rodent and arthrop population could occur and the diseases they ca may rapidly become the primary concern. Sanitati and pest control activities are disrupted even dur short disaster periods allowing harborages and bre ing materials to accumulate. These problems wo be compounded in case of nuclear attack by destr tion of equipment and chemical supplies and by long time accumulation of garbage, human wa and rubble.

One of the most serious problems will be the r ognition of diseases. Most physicians and health p sonnel will be unable to recognize exotic diseases endemic diseases which are rare today. Especially this be true of diseases spread by vectors. It is pr able that many of our laboratories will be destro and their personnel disorganized.

Persons responsible for sanitation and general hea in case of nuclear attack, possibly accompanied bacteriological warfare, should review the princi vector-borne diseases which may occur in this count They should know the vectors actual and poten geographic distribution. Species of mosquitoes wh are carriers of malaria, yellow fever, dengue, and various encephalitides are widespread in the south area. In the West, wild rodent plague serves a constant threat and may spread into the domestic population resulting in a fulminating epidemic pneumonic plague (a case of human plague was cently reported in Arizona). Flea-borne typhus, though milder than louse-borne typhus, is widely tributed throughout the southeastern states. Ro mountain spotted fever is transmitted by seve species of ticks widely found in nature. Tularemia, lapsing fever and tick paralysis may also be spr by these vectors. Various species of flies, in addit to carrying typhoid, food poisoning, diarrhea, dysentery, may cause myiasis in wounds of casualt

Arthropod and rodent vectors will also be of noyance to masses of people living under primi conditions and contaminate their food and water s plies. Stings and bites may cause severe reactions those hypersensitive to their venoms.

Pre-planning will be the key to the lives of man such disasters occur.

This article was prepared by Ewell P. Conyers, B.S., D.V.M. Principal Veterinarian, Zoonoses Control, Kentucky State Department of Health, Frankfort, Kentucky.



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective
GERIATRIC
antiarthritic
with
REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate-SF

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium para-aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe
PABALATE-SODIUM FREE

RECOGNIZE THIS PATIENT?



"The arthritis doesn't get any better... I can't get out. I never see anybody. It's awful to be sick... I was always so active."

When you recognize depression and anxiety related to an organic condition
—*add 'Deprol' to your therapy*

Typical organic conditions in which 'Deprol' helps control related depression and anxiety:

cardiovascular disorders ■ arthritis ■ cancer ■ menopause ■ alcoholism ■ obesity ■ asthma, hay fever and related allergies ■ chronic infectious diseases ■ dermatoses ■ G.I. disorders, and many other debilitating or life-threatening illnesses

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' relaxes physical tensions, restores normal sleep and revives interest in food.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is compatible with drugs used to treat co-existing organic conditions.
5. 'Deprol' is relatively nontoxic and free of side effects.

Deprol®

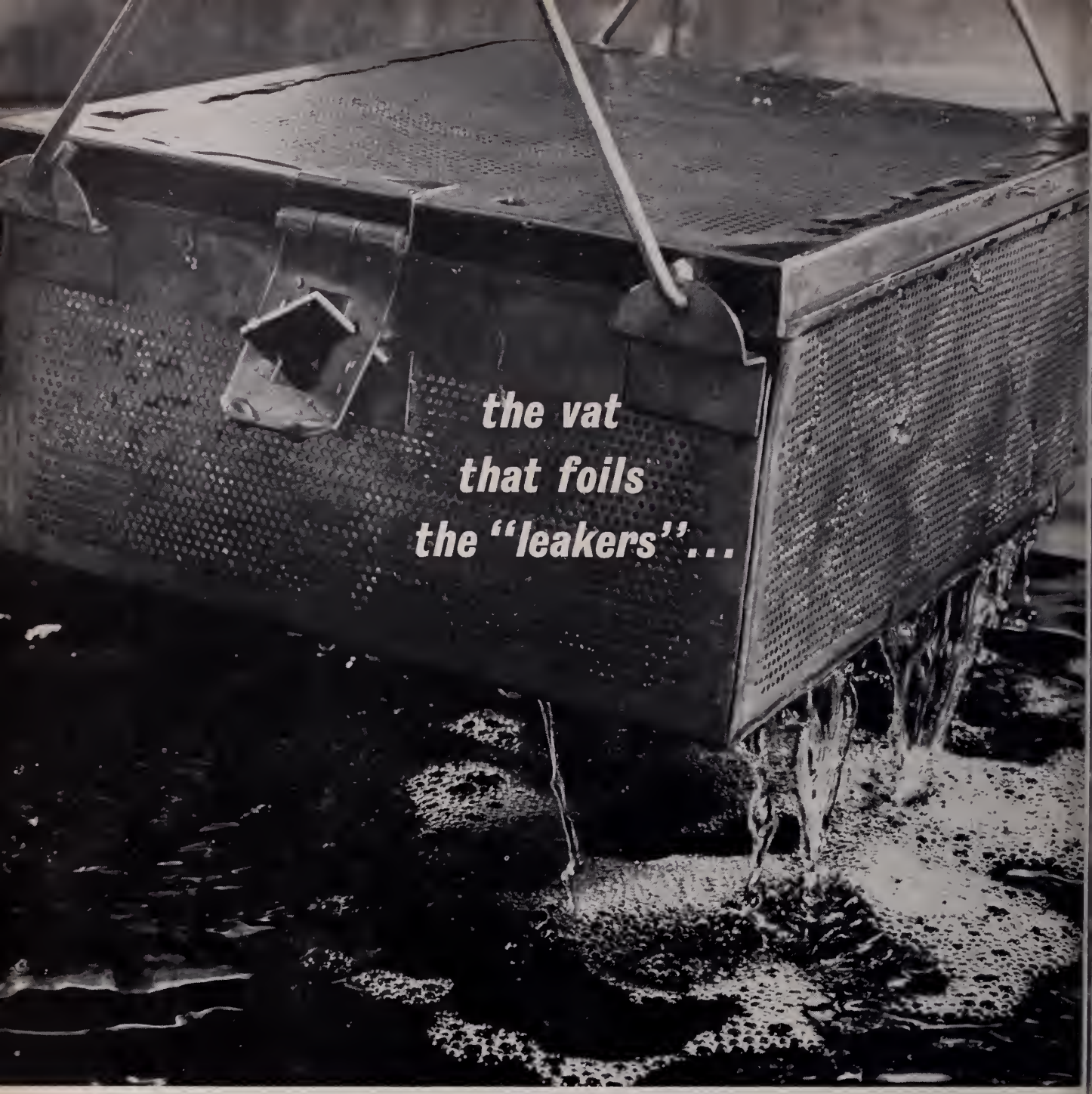
meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 tablet t.i.d. or q.i.d. May be increased gradually, as needed, to 6 tablets daily. With establishment of relief, may be gradually reduced to maintenance levels. **Supplied:** Light-pink, scored tablets Bottles of 50.

WALLACE LABORATORIES / *Cranbury, N. J.*

CO-801



"Leakers" are ampoules with minute imperfections in the seal. You can't readily see the flaw, and often it's so small that liquids won't even drip through; but microscopic contaminants can slip in to render the contents nonsterile and potentially dangerous. ▪ Detecting "leakers" is the job of the vat and the blue dye. ▪ Sealed Lilly ampoules are placed in baskets, submerged in a vat containing methylene blue, and subjected to a vacuum. If there is an imperfect ampoule in the lot, the liquid is forced out. When the vacuum is released, the blue dye rushes in. ▪ With dye as the spy, elusive "leakers" are quickly spotted and rejected . . . another of the many controls that add immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

400372

The JOURNAL of the
Kentucky State Medical Association

Issued Monthly Under the Direction of the Board of Trustees

VOLUME 62 MAY, 1964 No. 5

Cutaneous and Mucous Membranous Clues to Some Systemic Diseases†

Harold O. Perry, M.D.*
Rochester, Minn.

The cutaneous findings and clues to the diagnosis of some systemic diseases have been discussed. An adequate examination of the skin permits the physician to diagnose certain systemic diseases with greater ease and accuracy.

LESIONS either on the skin or on the mucous membrances of the oral cavity or the eyes may give a clue to the diagnosis of systemic diseases. These lesions may be nonspecific but localization to specific areas and the pattern of involvement are often suggestive, and may even be pathognomonic, of a specific disease entity.

In this paper, I shall discuss some of the clues related to lesions of the skin and the mucous membranes that lead to the diagnosis of systemic disease. These diseases become obvious to the physician who thoroughly inspects the cutaneous and mucous membrane surfaces. The proper interpretation of subtle alterations often opens vistas to the diagnosis of diseases not previously considered.

Rather than merely enumerating the cutaneous changes seen in certain systemic diseases, I prefer to discuss some of the clues that relate to the various organ systems of the body. Space alone will not permit this list to be complete, but I shall emphasize the value of such clues and the wide variety of diseases that are thus encompassed by an example or two from each category. By presenting the changes in one organ system of each disease state, I hope that concomitant pathologic changes in other systems will not be overlooked or considered unimportant; all must be appreciated and properly evaluated for optimal patient care.

Eyes

Nevoxantho-endothelioma. — Blindness is considered one of the severest fates that can befall man. In the infant or young child with either single or multiple, nodular xanthomatous-appearing lesions, nevoxantho-endothelioma must be considered. The blood lipids in this disease are not elevated as they are in the usual xanthomas. Except for the local nuisance value, these lesions are of no consequence because they eventually involute and disappear.

Appreciation of this cutaneous picture is important because similar lesions may be found within the eye. These growths may be misinterpreted as being malignant, and the eye might be sacrificed unnecessarily. The presence of a space-occupying lesion in the eye associated with the cutaneous lesions of nevoxantho-endothelioma should make the physician hesitate to initiate drastic ocular treatment. It would appear that there is no harm in merely observing the ocular lesion in the hope that perhaps, like those of the skin, it, too, will

†*Presented during the first General Scientific Session of the Kentucky State Medical Association Annual Meeting at Lexington, Ky., September 24-26, 1963.*

**Assistant professor of dermatology, Mayo Foundation, Graduate School, University of Minnesota; and consultant, section of Dermatology, Mayo Clinic, Rochester.*

gradually resolve; if it does, the patient's vision may return to a somewhat normal status.

Incontinentia Pigmenti.—This cutaneous reaction occurs primarily in females as a generalized vesicular eruption during infancy and as a verrucal-papular eruption during childhood. At about puberty it terminates in irregular whorls, bands, or streaks of hyperpigmentation of generalized distribution. The physician must be aware that this cutaneous reaction is associated with a number of ectodermal and mesodermal defects, which include mental retardation, epilepsy, spastic tetraplegia, imperfect dentition, defects of bones and joints, congenital heart disease, umbilical hernia, dystrophies of the nails, and patchy alopecia.

About a third of the children with incontinentia pigmenti have ocular changes, and half of these, namely one sixth of the entire group, have a mass in the posterior chamber of the eye. These masses are not neoplastic but resemble congenital retinal folds, although their differentiation from retrolental fibroplasia is difficult at times. Other ocular changes consist of strabismus, blue sclerae, cataracts, papillitis, chorioretinitis, and atrophy of the optic nerve. Incontinentia pigmenti is developmental in origin and seems to be a dominant pattern of inheritance in most instances. Because female children are most frequently involved, a sex linkage seems most probable.

Atopic Dermatitis. — Among the purely dermatologic conditions in which the eyes should be evaluated is atopic dermatitis. Cataracts may develop eventually in about 10 per cent of the patients who have this eczematous reaction, which most frequently begins in childhood and persists for an indefinite period (often into the adult years). Cataracts, of course, occur most commonly in those whose cutaneous reaction is the most severe and has persisted for a number of years.

Ears

Syphilis.—The combination of interstitial keratitis, eighth nerve deafness, and notched incisors has been recognized as Hutchinson's Triad and is indicative of hereditary syphilis. With the use of penicillin during and after World War II as an effective means of treating syphilis, the incidence of this disease had markedly decreased. Because of the present relative lack of fear of acquiring syphilis and the decrease in general knowledge of its prevention, the incidence of syphilis is increasing and perhaps more of these patients will be seen in the future.

A young child, who presents an eye problem diagnosed as a keratitis, who may have some dental anomalies and who may not be progressing in school as rapidly as expected, should have his hearing checked as this may be a paramount factor in his retarded mental development.

Nose and Throat

South American Blastomycosis.—A painful granulomatous reaction of the oral and nasal mucous membranes is one of the main clinical features of South American blastomycosis. Involvement of the mouth produces so much pain that eating, for the most part, is avoided by these patients, and they understandably suffer from malnutrition. In addition to the changes in the mucous membrane, cutaneous ulcerative granulomas, pneumonia, fever, and generalized muscular wasting are seen. The diagnosis of South American blastomycosis must be considered and can be confirmed by culturing the causative organism, Blastomyces dermatitidis, from cutaneous or oral lesions. In the present era of world-wide travel, one can expect to see an occasional patient, who, after traveling in South America, presents a combination of these signs and symptoms.

Teeth

Papillon-Lefevre Syndrome. — The skin, nails, hair, and teeth frequently participate in developmental diseases. In the Papillon-Lefevre syndrome, children have mild keratoderma of the palms and soles and at times also psoriasiform lesions on the knees and elbows and the areas of the Achilles tendon. An integral part of the syndrome is early loss of the deciduous teeth and the eventual loss of the permanent teeth—although they have erupted normally—so that these young patients are left edentulous. Consanguinity of the parents of these children is extremely common.

Neuromuscular System

Sturge-Weber Syndrome.—Although hemangiomas of the skin are frequently of greatest concern to the parent because of their cosmetic appearance, the presence of a port-wine stain involving one or all distributions of the trigeminal nerve should suggest to the physician the Sturge-Weber syndrome. In addition to the cutaneous reaction, angiomas of the meninges with calcification of the cerebral substance

results in epilepsy at times and in hemiplegia at other times. Glaucoma of the involved eye is common. The diagnosis of this syndrome is established on the basis of the cutaneous findings, encephalographic studies, roengenographic findings of the head, and ophthalmic and neurologic examinations.

Epiloia.—Children with closely grouped, uniform-sized red to flesh-colored papules on the central portion of the face should be evaluated neurologically. Children with adenoma sebaceum of the face also may be mentally deficient and epileptic; this trial of findings is referred to as epiloia. Other cutaneous lesions in this condition consist of connective tissue nevi, frequently of the lumbosacral region, regions of follicular hypertrophy, and vitiligo.

These patients should be properly evaluated with an electroenecephalogram, roentgenogram of the skull, and ophthalmologic examination and renal studies, including pyelograms, in an effort to discover possible tumors of the eyes, brain, or kidney.

Facial Hemiatrophy.—A cutaneous reaction often considered to be a form of scleroderma is referred to as facial hemiatrophy. In this condition the atrophy involves the tissues of one side of the face including the eyebrow, the eyelids, the face, the paramedian region of the scalp, and the underlying maxilla and mandible. More extensive involvement may occur, and then portions of the body, either on the same or on the contralateral side, show marked atrophy. These patients frequently have neurologic abnormalities, among which epilepsy is rather common.

Gastrointestinal System

Peutz-Jeghers Syndrome.—The presence of deeply pigmented macular areas on the lips and mucous membranes of the mouth, at the root of the nose, on the eyelids, and on the tips of the fingers and toes should suggest the Peutz-Jeghers syndrome. However striking the cutaneous involvement may be, the physician should not neglect to evaluate the gastrointestinal tract for polyps that may occur from the stomach to the rectum. The polyps may attain considerable size at times, and intussusception may become a problem. On other occasions, one or more of the polyps may be twisted on their pedicles, and bleeding with subsequent anemia may be of major concern. Fortunately in the Peutz-Jeghers syndrome, the polyps are benign and without evidence of malignant degeneration.

Gardner's Syndrome.—The polyps in the colon and rectum, which are seen in Gardner's syndrome with the cutaneous lesions that include sebaceous cysts, desmoids, and osteomas of the bone, invariably eventuate in carcinomatous degeneration. Thus, these cutaneous signs are of prognostic significance and must be considered in the clinical management of these patients.

Blue Rubber-Bleb Nevus.—Insight as to the cause of gastrointestinal hemorrhage may be gained whenever inspection of the skin and oral cavity reveals hemangiomatous lesions. Because these lesions are so deeply stained and present a wrinkled, redundant surface, they are referred to as blue rubber-bleb nevi. Similar hemangiomatous lesions can be found in the gastrointestinal tract and account for otherwise unexplained gastrointestinal bleeding or anemia.

Pyoderma Gangraenosum. — Pyoderma gangraenosum is characterized by rapidly developing necrotizing ulcers that frequently occur on the lower extremities but may be present anywhere on the body. Such lesions may be the presenting signs in a patient in whom ulcerative colitis is developing. Evaluation of the patient by proctoscopic examination and roentgenologic examination of the bowel may reveal ulcerative colitis. In some instances, however, pyoderma gangraenosum may be present independently of systemic disease.

Pulmonary System

Rendu-Osler-Weber Disease. — Hereditary hemorrhagic telangiectasia consists of widespread vascular dilatations and capillary tufts on the skin and within various organs. Cutaneous lesions are commonly present on the face, upper part of the trunk, extremities, and within the oral cavity and the nose. The otolaryngologist deals with this disease when lesions within the nose are disrupted and when either acute or chronic bleeding occurs. Bleeding within the gastrointestinal tract may be a problem. These cutaneous findings should alert physicians who are particularly interested in diseases of the lungs to the possibility that appropriate study may reveal the arteriovenous fistulae within the pulmonary tree.

Genitourinary System

Angiokeratoma Corporis Diffusum.—Vascular lesions in the form of small, uniform-sized angiomatous lesions with a keratotic surface distributed in the crease areas of the body

are a clue to the diagnosis of angiokeratoma corporis diffusum. Patients with these lesions may complain of various symptoms which include weakness, headache, dizziness, disturbed vasomotor function, numbness, paresthesia of the extremities, intermittent fever, and respiratory difficulties. Renal involvement is universally present and can be recognized by an examination of the urinary sediment and the finding of epithelial cells containing a doubly refractile fatty material. Biopsy of the kidney reveals fatty vacuoles within the glomeruli; similar fatty material is deposited in the muscle cells about blood vessels throughout the body. This fatty material is considered to be a diaminophosphatid, although its exact nature is not known.

Cardiovascular System

Xanthelasma.—At the present time when the lowering of blood lipids as a means of preventing atherosclerosis is being emphasized, the correct interpretation of xanthomas of the skin is made more frequently than heretofore. Xanthoma of the eyelids (xanthelasma) should alert the physician to the possibility that some of these patients, perhaps 50 per cent, have elevated blood lipids and that half of these (25 per cent of the total) may have some form of cardiac or peripheral vascular disease.

Pseudoxanthoma Elasticum.—Perhaps not so well known as indicative of peripheral or systemic vascular disease is the finding of barely perceptible flesh-colored papules arranged in a linear pattern in the crease areas of the neck, body, and extremities. Cutaneous lesions of pseudoxanthoma elasticum, which represent degenerative changes in the elastic tissue of the skin, should suggest that similar changes may be taking place within the elastic tissue of the blood vessels of the body, resulting in aneurysms, gastrointestinal hemorrhage, peripheral vascular disease, and at times epileptiform seizures. When the elastic tissue of the eye (Bruch's membrane) undergoes these same changes, rents and breaks in this tissue produce angioid streaks of the retina that are easily recognized by funduscopic examination. With extensive involvement, total blindness may occur.

Hematopoietic System

The cutaneous signs of diseases of the hematopoietic system may take the form of specific or nonspecific cutaneous reactions. As in other systemic diseases, urticaria, angioedema, erythema nodosum, erthema multiforme, herpes simplex, herpes zoster, purpura, and exfoliative dermatitis may indicate disease in this body system.

Lymphoma.—Red or violaceous indurated nodules and plaques of various sizes anywhere on the skin suggest lymphoma. These lesions may occur on the face, neck, and extremities as well as on the trunk. Because some of these lesions have a brightly erythematous hue and appear rapidly, they are mistakenly diagnosed as urticaria. The marked induration of such lesions, however, should suggest a specific lymphomatous infiltrate.

The oral mucous membranes readily reflect the blood dyscrasias. The most subtle changes consist of friability of the tissues with easy bleeding. As the disease progresses, the gums become spongy, and bluish tumors are seen on these parts. Generally speaking, the incidence of cutaneous lesions is highest in monocytic leukemia, but lesions are seen more frequently in lymphatic leukemia because of its more frequent occurrence.

Diseases of Metabolism

Porphyria.—Although the finding of large quantities or uroporphyrins in the urine is definitely pathognomonic for the porphyric states, the cutaneous pattern of patients with porphyria cutanea tarda is almost pathognomonic. These individuals have a peculiar suffused hue on the face, neck, and upper part of the trunk, which is composed partly of erythema and partly of increased pigmentation. Frequently the suffusion extends to the sclerae and conjunctivae so that these parts appear to be chronically irritated.

Where the face, ears, and dorsum of the hands are exposed to trauma or to the sun, vesicles, some of which may be hemorrhagic, can be seen. With rupture, these vesicles crust over and heal slowly to form atrophic scars. Additional cutaneous findings include a sclerodermalike appearance of the involved skin, hirsutism, milia, and darkening of the hair color.

Porphyria cutanea tarda may often be diagnosed on the clinical findings alone. A diagnostic test, which can be performed rapidly in the office, consists of placing the patient's urine in the beam of Wood's light and of observing whether a salmon-colored fluorescence of uroporphyrins is present. More detailed porphyrin analysis permits classification of these diseases into appropriate categories.

Diabetes Mellitus. — Although the classic triad of polydipsia, polyphagia, and polyuria suggest diabetes mellitus, atrophic plaques usually low on the leg, most often in the pretibial area, should not be overlooked as a clue to this disease. These plaques are well marginated and may vary in diameter from 1 to 15 or 20 cm. Centrally, there is apparent resolution of the process with the development of a yellowish brown hue to the residual sclerotic tissue and numerous telangiectatic vessels can be seen over the surface. Although the more central area of the lesion is resolving, the margin may show erythema and induration as evidence of its peripheral extension. Only a small percentage of patients with such lesions are found to be free of diabetes.

Thyroid Disease

The patient with hyperthyroidism has vitiligo, leukonychia, and a rather fine delicate skin that is frenquently moist. In hypothyroidism or myxedema, however, the skin becomes dry and coarse and the facial features are heavy and distorted because of mucinous deposits in the tissues. The tongue is thickened and enlarged, and the voice becomes hoarse because of similar involvement of the pharyngeal structures.

A localized form of hypothyroidism is now being seen more frequently than heretofore. Sharply demarcated, indurated plaques with a pigskinlike appearance most often occur on the lower extremities although they can be seen elsewhere on the body. These are areas of so-called localized pretibial myxedema, which develop in a patient whose hyperthyroidism has been treated either by operation or by I^{131}. The mucinous changes in the orbital tissues that produce the exophthalmos in hyperthyroidism are apparently responsible for the similar tissue changes in the cutaneous lesions.

Systemic Amyloidosis

Another condition in which the patient has a large tongue is systemic amyloidosis. In this disease, a peculiar proteinaceous material is deposited about the blood vessels throughout the entire body and within the substance of the muscles of the extremities, the heart, and the kidneys. The deposition of amyloid about the vessels makes these structures friable, and minor trauma to the skin produces regions of ecchymoses and cutaneous hemorrhage. Because there is not much tissue supporting the vascular structures in the eyelid, purpura of the lids is common in systemic amyloidosis and should always suggest its diagnosis. Generally, whenever the skin can be bruised easily, amyloidosis must be considered.

The diagnosis is proved most easily by appropriate biopsy of cutaneous lesions or by blind biopsy of the gingiva or the gastrointestinal tract. The physician must not overlook the rather frequent association of multiple myeloma with systemic amyloidosis; thus, the marrow should be examined for plasmacytosis, the urine for Bence Jones protein, the serum protein for elevated $alpha_2$ globulin, and the bony skeleton for regions of rarefaction.

Collagen Disease

Dermatomyositis.—Three entities, dermatomyositis, systemic lupus erythematosus, and scleroderma, often present cutaneous findings so similar that differentiation of these entities is impossible. This confusion is all too apparent when one considers the frequency with which the diagnosis of the combined disease is made, for instance, sclerodermatomyositis.

The classic cutaneous findings in dermatomyositis consist of a peculiar edematous quality of the face, which particularly involves the upper eyelids. These tissues have a violaceous pink hue often referred to as heliotrope. The same color changes can be seen on the prominences of the major joints as well as on the knuckles of the hands. When these findings are present independently, dermatomyositis probably should be suspected; and when muscular weakness of the proximal muscles of the extremities or the back is also present, dermatomyositis can be diagnosed easily. Confirmatory evidence by electromyographic studies, muscle biopsy, and serum transaminase determinations is helpful in establishing the diagnosis of this disease.

Systemic Lupus Erythematosus. — At the present time, systemic lupus erythematosus is diagnosed more frequently when cutaneous findings are absent than when they are present, merely because today lupus is infrequently associated with skin changes. Classically, a butterfly-shaped area of macular erythema on the face is a sine qua non for this disease. However, numerous nonspecific cutaneous patterns

including purpura, urticaria, erythema multiforme, Raynaud's phenomenon, and ischemic ulceration may form a part of the cutaneous ensemble of lupus erythematosus. Whereas in the past physicians depended on the laboratory configuration of leukopenia, an elevated sedimentation rate, hypoproteinemia, and proteinuria, they now confirm the diagnosis of lupus with greater assurance by more refined tests, such as the L. E. clot test and the fluorescent antibody tests.

In lupus erythematosus, the cutaneous eruption, when present on the hands, confines itself between the joints, in contrast to that seen in dermatomyositis where the eruption is on the knuckle. Clinically and histologically, the cutaneous changes in both lupus and dermatomyositis resemble each other to a marked degree.

Scleroderma.—Of the so-called collagen diseases, scleroderma is the one in which the collagen tissue of the skin shows such marked alterations histopathologically. Early in scleroderma, the sclerosis is manifested with involvement in the skin, but asymptomatic involvement of other organs can also be found. Acrosclerosis is the most common type of the disease, and, in this form, sclerosis of the face, upper part of the trunk, and the extremities is present in association with Raynaud's phenomenon. These changes occur first over the distal portions of the acra; then as the disease progresses, the reaction extends more proximally. In progressive sysemic sclerosis, a generalized reaction without Raynaud's phenomenon occurs.

Although the cutaneous pattern is the clue to the diagnosis of scleroderma, similar changes may take place in other organs and regions, particularly the lungs, gastrointestinal tract, heart, and kidneys. The consequences of these changes can be severe enough to cause death.

Summary

The cutaneous findings and clues to the diagnosis of some systemic diseases have been discussed as they might occur in a review of the systems of the body. No intent was made to present an all-inclusive list or to describe completely all of the changes that might be found. An adequate examination of the skin, however, helps the individual physician who is interested in general practice or in the specialized fields to diagnose certain systemic diseases with greater ease and accuracy.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

The Surgical Treatment of Heart Failure and Adams-Stokes Attacks from Complete Heart Block with a Cardiac Pacemaker†

FRANK C. SPENCER, M.D.,* BEN EISEMAN, M.D.,** AND J. T. REEVES, M.D.***
Lexington, Ky.

Two elderly patients, 70 and 74 years of age, with complete heart block causing severe cardiac failure and mild Adams-Stokes attacks, have been asymptomatic for 15 months following insertion of an internal cardiac pacemaker.

Introduction

RECENT experiences with two elderly patients treated with an implanted cardiac pacemaker have indicated that such therapy may be useful for cardiac failure resulting from heart block, as well as for the prevention of Adams-Stokes attacks. The risk of operation was minimized by preoperative cardiac stimulation with a catheter electrode introduced through a peripheral vein into the right ventricle. The increased cardiac rate obtained by electrical stimulation not only effectively treated cardiac failure before operation, but also decreased the risk of precipitating a fatal arrhythmia with introduction of anesthesia. These points are illustrated in the following case reports.

Case One. M. M.,‡ a 74-year-old white female, was admitted November 6, 1962 for increasing drowsiness and frequent Adams-Stokes attacks for the preceding two weeks. Until two years before admission she was physically active and performed her own housework, but subsequently was limited by exertional dyspnea and episodes of sudden unconsciousness. Initially these episodes were infrequent, lasted only a few minutes, and subsided without disability. Two months before admission the episodes became more frequent and severe bradycardia was noted; treatment with digitalis was stopped, but the bradycardia persisted.

Physical examination showed a lethargic, elderly female with a heart rate of 22/min. and a blood pressure of 160/40 mm. Hg. The liver was not palpable, and there was no edema of the legs. Moderate cardiomegaly was found on the chest roentgenogram. The electrocardiogram confirmed a complete heart block with a ventricular pacemaker. The blood urea nitrogen was elevated to 122 mg. percent, though serum electrolytes were near normal values: sodium 140 meq./l., potassium 4.8 meq./l., CO_2 22 meq./l., and chloride 93 meq./l. The hematocrit was 48%.

An intravenous infusion of isoproterenol (Isuprel®) was promptly begun at a rate of 5 micrograms/min. and continued for 48 hours. This increased the cardiac rate to 40-50/min., but recurrent ventricular tachycardia required frequent change in the rate of infusion. The increased cardiac rate initiated a mild diuresis, which lowered the blood urea nitrogen to 70 mg. percent 48 hours after admission. This decrease in the urea nitrogen suggested that much of the severe renal insufficiency was due to cardiac failure from the slow heart rate, and indicated that surgical implantation of an artificial cardiac pacemaker would be effective.

This operation was undertaken November 9, 1962, three days after admission. Before

†*Presented before the Annual Meeting of the Kentucky Surgical Society held May 17-18, 1963 in Lexington, Ky.*
**Professor of surgery at the University of Kentucky College of Medicine, Lexington, Ky.*
***Professor and chairman of the department of Surgery at the University of Kentucky College of Medicine.*
****Assistant professor of medicine at the University of Kentucky College of Medicine.*
‡*Referred by R. F. Jasper, M.D., Somerset, Ky.*



Figure 1. The Electrodyne pacemaker (6x6x2 cm.) is enclosed in a Teflon net and placed beneath the left pectoral muscle near the axilla.

anesthesia was induced, a catheter electrode was introduced under fluoroscopic control through the right external jugular vein into the right ventricle and attached to an external pacemaker. Cardiac stimulation at a rate of 70/min, was then begun, after which the patient was anesthetized.

The chest wall was incised in the left anterior fifth intercostal space, after which a permanent pacemaker (6 x 6 x 2 cm.) was implanted near the axilla beneath the left pectoral muscle. (Fig. 1). The two stimulating wires from the pacemaker were brought through the chest wall and inserted near the apex of the left ventricle. (Fig. 2). As these wires were inserted into the myocardium, ventricular fibrillation began but spontaneously subsided in about 30 seconds. The spontaneous reversion probably occurred because the intracardiac catheter electrode continued to stimulate at a rate of 70/min. When the permanent pacemaker then began to stimulate at a rate of 72/min., the catheter electrode was removed. The operative procedure required about one hour.

Postoperative convalescence was delayed by recurrent dysphagia and vomiting which were never adequately explained. Roentgenologic studies of the gastrointestinal tract showed no abnormalities. The blood urea nitrogen remained between 40 and 50 mg. percent until November 21, 1962, but decreased to 28 mg. percent by November 24, 14 days after operation. On November 19 an unsuspected hypocalcemia was found (calcium 3.2 meq./l., phosphate 2.8 meq./l.) and confirmed by similar findings on November 20. Oral administration of calcium elevated the blood level to 4.3 meq. by November 23 and the phosphate to 5.9. Thereafter, the patient steadily improved and was discharged on November 27. Physical vigor gradually returned in the next two months. Oral administration of calcium was stopped three months after operation, after which blood calcium concentrations remained normal. Nine months after operation, she was asymptomatic, with no signs of cardiac failure, and had a blood urea nitrogen of 20 mg. percent.

Case Two. M. H., a 70-year-old white female, was admitted on January 5, 1963 because of a severe Adams-Stokes attack. Her first such episode had occurred eight months earlier and was followed by similar attacks every three or four weeks. After beginning with dizziness and blurred vision, these episodes were quickly followed by loss of consciousness, causing her to fall to the floor. Spontaneous recovery occurred in 15-20 minutes without any residual symptoms. Apparently unrelated to the present illness was the fact that an uncomplicated thyroidectomy had been performed for thyrotoxicosis 12 months before admission.

Physical examination showed a confused, elderly female with the classical signs of severe cardiac failure—distended neck veins, cardiac enlargement to the anterior axillary line, a liver palpable 5 cm. below the costal margin, and marked swelling of the legs. The pulse rate



Figure 2. The two stimulating electrodes are inserted into the left ventricle near the apex of the heart. The wires remaining outside the heart are insulated with Teflon.

was 30/min. with a blood pressure of 170/50 mm. Hg. A chest roentgenogram showed moderate cardiac enlargement with pulmonary congestion. The electrocardiogram showed a complete heart block. Blood chemical analyses were not grossly abnormal: hematocrit 44%, sodium 134 meq./l., potassium 4.1 meq./l., CO_2 16.5 meq./l., chloride 90 meq./l., and urea nitrogen 17 mg. percent.

Intravenous infusion of isoproterenol did not significantly increase the cardiac rate but did cause nausea and vomiting. The patient was therefore immediately taken to the cardiovascular laboratory and a catheter electrode inserted through a right arm vein into the right ventricle. With an external pacemaker, cardiac stimulation was begun, and serial cardiac outputs measured with the cardiogreen dye technique[2] as the heart rate was increased from 38 to 80 beats per minute. The cardiac output was only 3.1 l./min. at a heart rate of 38 min., but rose to 4.7 l. when the rate was increased to 62/min. Raising the rate to 70/min. increased the cardiac output to 5.6 l./min., but subsequent increase in cardiac rate to 80/min. did not alter the cardiac output (5.2 l./min.). The external pacemaker was accordingly adjusted to a rate of 70/min.

The increased cardiac rate lowered the venous pressure from 20 to 10 cm. of water. Within the next few hours there was a diuresis of 1600 ml. of urine, and over 4 liters of urine were excreted in the following 36 hours. During this time she was digitalized with digoxin. Fifty mg. of heparin were given by subcutaneous injection every six hours to minimize the risk of clotting about the catheter electrode in the right ventricle.

Forty-eight hours after admission she was taken to the operating room and a permanent pacemaker implanted, using a technique similar to that described in the first patient. Once the permanent pacemaker was stimulating at a rate of 72/min., the catheter electrode was removed.

Following an uneventful convalescence, she was discharged six days after operation. Two weeks later she was asymptomatic with the pacemaker stimulating 72 beats per minute. Seven months after operation she remained free of symptoms and was performing her own housework.

Discussion

Following the developmental work by Hunter and Roth,[4] Zoll and Frank,[6] and Chardack,[1] internal pacemakers have been implanted with increasing frequency for the treatment of Adam-Stokes attacks from complete heart block. Some such units have now been functioning over three years. Fortunately, infection has not been a serious problem, which is in marked contrast to experiences with permanent *external* pacemakers, where infection inevitably occurred sooner or later about the wire passing through the chest wall. The batteries in the pacemaker should last for five years, after which replacement of the unit in the axilla will be necessary, though the pleural cavity will not have to be re-entered.

The two elderly patients described in this report had such severe cardiac failure both the safety and value of implantation of a pacemaker were uncertain before operation. Furthermore, in the first patient the question naturally arose regarding the reversibility of the renal insufficiency. These uncertainties were quickly resolved in both patients by the prompt improvement when the cardiac rate was increased, using isoproterenol in the first patient and a catheter electrode in the second.

These observations coincide well with those made in the experimental laboratory with heart block, for a dog with a surgically produced heart block promptly develops congestive heart failure, which subsides when the cardiac rate is artificially increased with a pacemaker.[5] The conclusion seems justified, therefore, that a permanent cardiac pacemaker may be helpful when a patient with a heart block develops severe cardiac failure which does not respond to simpler methods of treatment.

The value of a catheter electrode in the management of these patients should be emphasized. It has been used too seldom, partly from lack of familiarity with the technique and partly because of fear of intravascular clotting about the catheter. If anticoagulants are used, the hazard of clotting has been demonstrated to be slight, for Furman and Hurwitt have reported the treatment of patients with catheters left in place for several months.[3] The obvious goal in treatment, whether the problem be congestive failure or Adams-Stokes attacks, is to increase the heart rate. When this cannot be done with isoproterenol or other drugs, a catheter electrode should be inserted promptly. External

pacing with electodes taped to the chest wall can be tried, but usually the discomfort associated with the electrical stimuli precludes stimulation for more than a short time.

If a catheter electrode is not required before operation, it should be inserted before anesthesia is induced. The main risk of operation upon a patient with complete heart block is ventricular fibrillation, either with induction of anesthesia or during the operative procedure. If the heart rate is increased to a normal range, the risk of fibrillation is greatly decreased. Operation then becomes a relatively innocuous procedure. Electrical pacing through a catheter electrode so effectively reduces the risk of ventricular fibrillation, it should be seriously considered when *any* operation, such as an appendectomy or a cholecystectomy, is required upon a patient with a complete heart block.

Summary

Two elderly patients, 70 and 74 years of age, with complete heart block producing cardiac failure and Adams-Stokes attacks, have been asymptomatic since insertion of an internal cardiac pacemaker nine months ago. A preoperative blood urea nitrogen of 120 mg. percent in one patient decreased to 20 mg. percent after the cardiac failure had been corrected with the pacemaker. Electrical stimulation through a catheter electrode inserted into the right ventricle through a peripheral vein was of much value both in treating cardiac failure before operation and in avoiding ventricular fibrillation during operation.

References

1. Chardack, W. M., A. A. Gage, and W. Greatbatch: *Correction of Complete Heart Block by Self-Contained and Subcutaneously Implanted Pacemaker.* J. Thor. Cardiov. Surg. 42: 815-825. 1961.
2. Fox, I. J., L. G. S. Brooker, D. W. Heseltine, H. E. Essex and E. H. Wood: *A Tricarbocyanine Dye for Continuous Recording of Dilution Curves in Whole Blood Independent of Variations in Blood Oxygen Saturation.* Proc. of Staff Meetings of Mayo Clinic 32: 478, 1957.
3. Furman, S., J. B. Schwedel, G. Robinson, E. S. Hurwitt: *Use of an Intracardiac Pacemaker in the Control of Heart Block.* Surgery 49: 98-107, 1961.
4. Hunter, S. W., N. A. Roth, D. Bernardez, and J. L. Noble: *A Bipolar Myocardial Electrode for Complete Heart Block.* Lancet 79: 506, 1959.
5. Starzl, T. E., and R. R. Gaertner: *Chronic Heart Block in Dogs. A method for Producing Experimental Heart Failure.* Circulation. 12: 259-269, 1955.
6. Zoll, P. M., H. R. Frank, R. N. Zarsky, A. J. Linenthal and A. H. Belgard: *Long-term Electric Stimulation of the Heart for Stokes-Adams Disease.* Ann. Surg. 154: 330-346, 1961.

Plan to Attend —

AMA Annual Meeting

San Francisco, June 21 - 25

KSMA Annual Meeting

Louisville, Sept. 29 — Oct. 1

"Hematologic" Tumors of the Head and Neck†

Giovanni Raccuglia, M.D.*

Louisville, Ky.

Tumors of the head and neck are often of hematologic pertinence. Suggestions for the recognition of the hematologic disease underlying these manifestations are given.

SINCE the primary purpose of this presentation is to offer broad directions in diagnosis and treatment of hematologic diseases which become manifest with changes observable in the head and neck, the exposition will retrace the ordinary techniques of the clinical work-up of the physician confronted with a complaint or a physical finding. Therefore, a regional rather than a pathologic or nosologic classification will be followed. As customary,[1] diseases of the central nervous system will be excluded. In view of the fundamental differences in incidence and types of tumors between infancy and adulthood, a division between the pediatric and adult group will also be maintained in the discussion. The word "tumor" is interpreted very broadly, as defined in Webster's, "swollen or distended part". The presentation is intended to be selective and confined to specialized and more unusual problems.

Skin, Subcutaneous Tissue and Mucosae

Occasionally the patient seeks medical assistance because of changes in these organs due to systemic diseases of hematologic pertinence. An infiltration of the skin, either undefined or discrete, usually movable, rubbery in consistency and painless, may be the first indication of a lymphoma, usually a lymphosarcoma or a reticulum cell sarcoma, more rarely Hodgkin's disease. Leukemic infiltrations of the skin of the head and neck are rare, but the hypertrophy of the gums in acute leukemia, especially the monocytic or granulocytic varieties, is well known.

Sarcoidosis was felt for many years to be exclusively a skin disorder. Its manifestations may involve the face and take the form of reddish-blue papules, nodules, infiltrated plaques or subcutaneous masses. Mucuous membranes may be involved with the same lesions. Diascopy may show small granulomas visible as yellow points.

The reticulo-endothelioses (Hand-Schüller-Christian disease, Letterer-Siwe disease, and eosinophilic granuloma), more often observed in children, frequently manifest skin changes. The lesions of Hand-Schüller-Christian disease may be cyst-like swelling of the scalp, yellowish papules or typical xanthelasma. Swelling and necrosis of the gums with extrusion of the teeth is the result of the underlying bone involvement. The skin lesions of Letterer-Siwe disease are often papular, with a yellowish center, surrounded by a red border. More often the lesions are purpuric. The disease is characterized by a rapid infectious-like course and generalized lymph node involvement. The skin lesions of the eosinophilic granuloma have been described only rarely and are characterized by erythematous ganuloma, sometimes ulcerated, and by plaques.

While vascular tumors are not usually considered of hematologic pertinence, the peculiar systemic bleeding tendency associated with giant hemangiomas should be mentioned.[2] This is almost exclusively seen in small children and in no way differs from the bleeding tendency associated with thrombocytopenia. Absence of platelets is in fact detected by the examination of the blood. The hemangioma is often located in the face or in the neck. Thrombocytopenia develops as a secondary phenomenon: the abnormal endothelium of the tumor sequesters the circulating platelets and the production of these elements is insufficient to replace the

†*Presented at the fourth General Scientific Session of the Kentucky State Medical Association Annual Meeting held in Lexington, Ky. September 24-26, 1963.*

**Director of the section of Hematology of the department of Medicine at the University of Louisville School of Medicine, Louisville, Ky.*

losses. Radiation therapy destroys the tumor and the regression is associated with re-appearance of circulating platelets. If the systemic bleeding of the child is severe, this is a very good indication for platelet transfusion.

The examination of the mucuous membranes may reveal infiltrates, hypertrophy and hemorrhagic manifestations associated with lymphomas or leukemias. A persistent tonsillar hypertrophy in an adult should raise the suspicion of lymphosarcoma or reticulo-endothelial cell sarcoma. Macroglossia may be an indication of amyloidosis.

Lymph Nodes

Lymph node enlargement of the cervical or head regions is, of course, a symptom for which the hematologist is often called in consultation. It should be pointed out immediately that the experience of the specialist does not substitute for the indication of biopsy. The hematologist relies on the pathologist, as any other physician must, for confirmation or exclusion of a serious diagnosis. The indication for biopsy may, however, be limited by the knowledge of unusual manifestations of benign conditions. Also a complete evaluation of the peripheral blood and a bone marrow examination *should precede* the lymph node excision, since these may offer the diagnosis and make the biopsy unnecessary. This is the case, for example, of the lymphadenopathy of leukemias, usually acute or chronic lymphocytic, where a biopsy is almost always unjustifed.

Infectious mononucleosis is a benign condition which is responsible for a large number of the unnecessary biopsies. Cervical lymphadenopathy may induce the patient to seek medical assistance before the blood changes or the appearance of the heterophil antibodies takes place or a lymphadenopathy may persist for months after the antibody titer has substantially decreased. Positivity of the heterophil antibody test and presence of at least 50% of atypical lymphocytes is required by some authors[3] in order to make the diagnosis of infectious mononucleosis. If these criteria would be rigidly applied, however, a large number of cases would undoubtedly remain undiagnosed. It is common experience in fact, to encounter patients with cervical lymphadenopathy, sore throat, a typical lymphocytosis but with negative Paul-Bunnel reaction. While it is conceivable that they may have a different viral infection, the name "infectious mononucleosis" is sufficiently inexact, non-specific and symptom-defining to include those cases. Unusual manifestations of this disease associated with cervical lymphadenopathy should be known. These include thrombocytopenia, meningeal irritation, myocarditis, spleen rupture (occasionally occuring in an undiagnosed case or resulting from excessive palpation), edema of the eyelids, pancreatitis, albuminuria, and hematuria. On the other hand, nasal discharge, productive paroxysmal cough, chest pain, arthralgia, and profuse diarrhea are practically unseen and almost exclude this diagnosis. Liver involvement is more common than it is realized. Hepatomegaly is found in about 10% of cases, chemical evidence of liver damage is almost constant, but the development of overt jaundice is infrequent (5%). Repulsion for smoking which these patients manifest has been considered an indication of liver involvement.

A persistent painless lymphadenopathy especially of the posterior cervical triangle in an adult should be envisaged with a high degree of suspicion for lymphoma. The presence in these individuals of an enlarged and hard spleen should be regarded as an absolute indication for hematologic evaluation and possibly lymph node biopsy. A pain referred to a tumor of the neck within a few minutes following the ingestion of even small quantities of alcohol should raise the suspicion of Hodgkin's disease. This unexplained symptom is present in approximately 15% of patients with this disease[4].

Lymphadenopathy of children is usually benign. It may appear long after a minor respiratory infection or a viral infection has subsided. A node biopsy in children should always be considered as a last resort. It should, however, be kept in mind that Hodgkin's disease and lymphosarcoma are not unknown in children. Acute leukemia may, of course, initiate with lymphadenopathy but this diagnosis should be ruled in or out by hematologic studies alone. The already mentioned reticulo-endothelioses will constantly manifest lymphadenopathy at one time or another[5]. It should finally be remembered that 50% of normal adults and possibly a larger percentage of children have palpable lymphnodes of no significance[1].

Bony Structures of the Head and Neck

Only rarely the localizations of systemic hematologic disorders in the bony structures of the head and neck are manifested by other than radiologic symptoms. Diabetes insipidus may be the first symptom of Hand-Schüller-Christian disease. A skull x-ray obtained to investigate the presenting complaint may reveal the characteristic bone lesions. In some of these patients masses may appear over the cranium or soft, painless areas in the skull are noted on palpation. Radiologically, lesions such as erosions of the sella turica or of the inner table and/or of the calvarium are often demonstrable. The radio-lucent areas are distinct and sharp without surrounding bone reaction. The remainder of the reticulo-endothelioses, as well as Gaucher and Niemann-Pick diseases, may produce analogous radiologic changes.

Multiple myeloma may become evident through masses in the skull or pathologic fractures of the spine. Occasionally, symptomatic involvement of the jaw is encountered. Accompanying radiolucent lesions of the skull or other bones, as well as the presence of serum protein changes and the bone marrow picture complete the diagnosis.

Lymphosarcoma involves the bone and periosteum in over 70% of the cases, but radiologically demonstrable lesions are present in only 10 - 15%.

While bone pain is quite a common complaint of leukemic patients, especially children, the head and neck are usually spared from this symptom. Involvement of the cranial bones is, however, common in the form of tumors, periosteal infiltration, destruction and absorption of bones[6]. Chloroma is a peculiar leukemic tumor which may involve the skull, the orbit, the paranasal sinuses, the spine, and other bones. The systemic picture of the disease is indistinguishable from that of leukemia.

Other Structures of the Head and Neck

Involvement of the eye and its adnexa is not unusual in hematologic disorders. Lymphosarcomatous infiltration of the eyelid and of the conjunctiva is occasionally observed.

Proptosis due to retrobulbar tumor growth is observed in myeloma, lymphosarcoma, and reticulo-endothelial cell sarcoma.

A symmetrical painless enlargement of the salivary and lacrimal glands by leukemic or lymphomatous tissue is known by the eponym of "Mikulicz syndrome." This represents a participation of the above mentioned structures in the generalized process and should be differentiated from "Mikulicz disease" which presents the same clinical features but is a self-limited, benign condition of unknown etiology characterized by lymphocytic and epithelial infiltration of the glands. Sarcoidosis may present a similar type of localization. The first manifestation of a reticulo-endotheliosis may be an "otitis" resistant to any form of treatment. The symptoms are usually due to bone erosion.

Treatment of Tumors of the Head and Neck

An exhaustive discussion of the therapy of these diseases is outside the purpose of this presentation. A few points, however, deserve a brief comment. The preferred methods of treatment of leukemias are presently those based on chemotherapy. Chemotherapy is rapidly expanding in the field of broader cancer therapy, and the hematologist finds himself more and more concerned with treatment of disseminated tumors of non-hematologic nature. In the treatment of head and neck tumors, however, a team effort is often necessary. Perfusion of the head with antifolic compounds or nitrogen mustard is the domain of the surgeon. Excisions are occasionally indicated for palliation. X-ray therapy is still the treatment of choice of the non-disseminated lymphoma. Some authors advocate the routine administration of cytotoxic agents following x-ray therapy even in these forms. The radiologist, furthermore, often requires temporary interruption of chemotherapy during x-ray treatment. This makes cooperation between specialists mandatory. X-ray therapy is also indicated, in conjunction with chemotherapy, if a disseminated disease manifests itself with a massive regional involvement. Such may be the case in disseminated lymphosarcoma or reticuloendothelial cell sarcoma with outstanding tonsillar enlargement, myeloma with vertebral erosion causing severe pain, or chronic lymphocytic leukemia of only moderate systemic activity but causing enormous, disfiguring cervical or facial adenopathy.

While several thousand chemotherapeutic agents have so far been employed for treatment of malignancies, relatively few of them are today in routine use. These include nitrogen

Continued on Page 409

Cancer of the Ovary—The Need for Early Diagnosis†

Allen E. Grimes, M.D.,* and Harold Redd, M.D.**
Lexington, Ky.

The insidious onset contributes to the 40% inoperability, and the average 30% five year cure in women with cancer of the ovary. More frequent vaginal examinations in women past 40 might lead to earlier diagnosis.

A RECENT study of our 32 cases of carcinoma of the ovary re-emphasized the gravity of this disease. Everyone writes in terms of five year survival, for instance, Munnell and Taylor[15] report 27.5%, Wheelock, Fennell and Meigs[25], 28.4%, Kerr and Elkin[8], 30.4%, and Majewski[13], 20.3%. Munnell and Taylor further add that at the end of one and a half years, about 60% of these people have died. We made an extensive review of the literature, and found certain recurring facts which if universally known might lead to earlier diagnosis and effective treatment.

The disease, according to Randell[21], occurs in nine women in a thousand over 40, and 14 women in a thousand after 50 years of age. Evidently it is predominantly a disease of middle age, but spares no age group. It may occur in approximately six percent of women under 30 years of age, and is not unknown in childhood. In fact, Tausigg[11] rates the ovary the most common site of neoplasm in childhood. Statistically, Abel[1] finds carcinoma of the ovary third in frequency of the malignancies of the female tract. It is primary in the cervix in 90%, the endometrium in 6.1%, and the ovary in 4.9%. The above data has valuable clinical use. The higher incidence of ovarian carcinoma in the fourth and fifth decades, and the knowledge that 70% of all ovarian neoplasms develop before the age of 50, makes pelvic and rectal examination an absolute requirement when women in these age groups consult you. You must also keep in mind that many of these lesions initially have no pelvic symptoms but cause vague gastro-intestinal distress which may be misleading.

Problems of Diagnosis

In an effort to pinpoint the responsibility for the errors in the diagnosis of carcinoma of the ovary, the Philadelphia Committee for the study of pelvic carcinoma reviewed the records of 210 such patients. Leib J. Golub[6] reported the following findings. In 34.8% of the cases, the patient was entirely at fault. She either delayed coming for examination because she thought her symptoms insignificant or unimportant, she feared the possibility of a malignancy, or she was deterred from seeking medical aid because of financial difficulty. In 17.1% of the cases the physician failed to make a pelvic examination, and in 12.4% the physician and the patient did not correctly evaluate her symptoms. Falling in this last category are patients with gastrointestinal discomfort, urinary disorder, or distress unrelated to the genital tract. The doctor was totally or partially responsible for the failure in the diagnosis in appoximately 30% of the cases.

Improved patient education has brought to their attention the significance of abnormal vaginal bleeding and new and unusual vaginal discharges. Now they come earlier for examination to determine the cause of these changes. But few understand the need for periodic examinations when no symptoms are present. It has been estimated that ovarian carcinoma may be present eight to nine months before the diagnosis is made. Therefore, examinations every six months rather than yearly should be required for women over 40 years of age. All evidence indicates that this disease is often silent at the

†*Presented before the Annual Meeting of the Kentucky Surgical Society at Lexington, Ky. May 17-18, 1963.*

**Assistant professor of clinical surgery at the University of Kentucky College of Medicine.*

***Instructor of clinical surgery at the University of Kentucky College of Medicine.*

onset, and rarely acute or explosive at its beginning. The true pelvic cavity is comparatively large, and can accommodate or adjust to a slow growing tumor before its bigness gives pressure symptoms or invasion alters the function of adjacent viscera, disturbs the menstrual function or produces ascites. Early detection before extension and wide spread involvement must, therefore be our goal if our cure rates are to be improved.

The pain or discomfort of this disease when present is more often in the lower abdomen, but may be in the upper quadrants. The distress may be merely a sense of pressure, weight or heaviness. The first symptom, on the other hand, may simply be an enlarging abdomen called to the patient's attention by the tight fitting of her clothes. Self examination may then reveal the tumor. More often, there is a weight loss rather than a gain. Ascites and accompanying edema of the legs may arouse the patient's suspicion and send her to you. If the bladder is involved, there is frequency, urgency, dysuria, and occasionally pus and blood. When the rectum is invaded, there may be a sense of pressure, pain, constipation, diarrhea, blood in the stools. Vague dyspepsias with flatulence, anorexia, nausea, vomiting, easy fatigability, and weight loss often indicate extensive disease. Vaginal bleeding, either menorrhagia or metrorrhagia, or both, occurs in approximately 24% of these patients. These symptoms alone make a vaginal examination an absolute necessity. This cannot be over-emphasized. Too many hospital charts contain the following note, "vaginal examination deferred". We discovered this unhappy oversight in several of our referred patients.

We found functioning tumors of the ovary in a somewhat different category, and in a great minority. They present distinctive and additional symptoms to those previously described. The arrhenoblastomas, rarest of all, with less than a hundred cases reported in the literature, have rather characteristic manifestations. Patients with this tumor often have increased body hair, an enlarged clitoris, flattening of the breasts, and amenorrhea. Dysgerminomas, relatively benign, are epithelial neoplasms structurally identical with the seminoma of the testes. They occur more frequently in the younger age groups. This tumor retains the shape of the ovary and has a rubbery consistency, except the larger ones, which are subject to areas of necrosis and softening. The Ascheim-Zondek test is positive in these cases, and is of particular value in making the correct diagnosis. The fact that this tumor is of a relatively low grade of malignancy encourages the surgeon to conservative treatment in the younger patients. The granulosa cell tumors also found predominantly in the younger age groups may be spared radical surgery. Abnormal uterine bleeding resulting from excessive estrogenic activity is frequently the presenting symptom. Cystic teratomas tend to run a relatively benign course, however approximately 11% become malignant. Unfortunately, there are no early signs or symptoms to denote this transition.

Secondary Carcinomas

The symptoms of carcinoma metastatic in the ovary are likely to be overshadowed by the manifestations of the primary tumor. In the order of frequency the primary lesion occurs in the breast in 34%. Incidentally, this statistical fact may give added value and support to the present trend of oophorectomy as supplemental treatment of patients with carcinoma of the breast in the pre and early post-menopausal states. The stomach is the initial site in 15.2%, the fundus uteri in 6.7%, the cervix in six percent. Carcinoid of the appendix has been reported on occasions, the kidney rarely, and the colon in approximately five percent of the cases. With particular reference to metastatic carcinoma arising from the colon, it has been suggested that bi-lateral oophorectomy be included in the radical surgical treatment for carcinoma of the lower sigmoid and rectum in all women. This small incidence of five percent however, is no greater than that of all patients who have had one primary carcinoma.

In our experience with carcinoma of the lower colon, the need for castration has not been borne out.

Aids to Diagnosis

There are several aids to the diagnosis of carcinoma of the ovary, and they will be mentioned. But in the final analysis we depend on the bi-manual vaginal examination. The Papanicolaou vaginal and cervical smears are reliable for cervical carcinoma, of relatively little value for carcinoma of the fundus, and of no practical merit in the early diagnosis of ovarian carcinoma. The diagnostic D.&C. is a universally accepted means of investigating abnormal uterine bleeding, but of comparatively

little value for suspected ovarian malignancies.

The patient's age and the size of the tumor definitely influence the extent of one's investigation. Young women under 40 more frequently have the innocent Graafian follicle, and corpus luteum cysts averaging 5 cms. in diameter. There is a tendency for this cyst to reduce in size or disappear in a large majority of patients in four to five weeks. This period of observation for re-examination may be safely awaited. Tumors of the older age group of women may be cystic or solid, are usually greater than 8 cms. in diameter, are more likely to be malignant, and more urgently require definitive diagnosis, which generally means abdominal exploration. Histological diagnosis is necessary in order to preserve normal functioning tissue and avoid leaving malignant tissue when a more radical procedure is indicated.

Despite the increased public awareness of the necessity for early detection of cancer, it is the doctor's ultimate responsibility. One of our major conflicts relates to the sacrifice or conservation of the ovaries at the time of pelvic surgery for benign lesions. Since the majority of cases of carcinoma of the ovary occur in patients over 40 years of age, it has been suggested by some that all such women being operated upon for benign pelvic conditions should have their ovaries removed. Among the supporters of this view, are Allan and Hestig[2] who found that 22.6% of women of this age group with carcinoma of the ovary had undergone previous pelvic surgery, and in 29% of them the ovarian tumor was discovered within two years following the previous operation. Fulton stated that 52% of his cases were at least 40 years of age at the time of their first operation, and 20% had already passed the age of 50.

The desirability of preserving the ovaries in young women is unquestioned. The following remarks therefore concern the preservation of the ovaries in the older women. Randall[21] has stated that since ovarian carcinoma does not exceed nine in a thousand women over 40, he believes that by practicing so-called prophylactic oophorectomy each of us in a lifetime would probably save only one woman from carcinoma, and plunge many into the discomforts of an early menopause. Prophylactic oophorectomy coincidentally with surgery for benign lesions, is obviously advocated in the belief that any remaining function of the ovaries is not worth the risk of malignancy. Marchetti[12] has said that ovarian function is altered but not ended with the cessation of menses. Cervical and vaginal smears in these women often show adequate estrogenic activity.

In some women vaso-motor, nervous and emotional instability may follow routine removal of their ovaries years after the cessation of menses. Menopausal osteoporosis is well known. Carbohydrate metabolism and the mobilization of the glucose reserve are also influenced by the menopause. Of more recent interest is the clinical evidence of estrogenic protection against arterio-sclerosis. This claim is supported by the finding of a higher degree of coronary arterio-sclerosis in women over 50 who have had a bi-lateral oophorectomy. The vascular change is less marked in control groups. Siddell and Levine[22] offered a compromise measure in which they advocated the removal of one ovary, preferably the left, to reduce the incidence of malignancy by 50% and retain the valuable hormonal influence of the residual ovary.

Treatment

The treatment of this formidable disease consists of surgery, x-ray, cobalt, radio-active gold and phosphorus, and the anticarcinogenic drugs. The selection or combination of these modalities depends upon the available facilities and the surgeon's preference based on his experience, but to a larger degree on the extent of the disease. Without gross evidence of local or distant spread, and negative cytological studies of pelvic peritoneal washings, some advocate a total abdominal hysterectomy with bilateral salpingo-oophorectomy as adequate treatment. Many surgeons feel that the poor prognosis in this disease makes it necessary to utilize initially all means of treatment, that is, surgery, irradiation, and the anticarcinogenic drugs. The fields of usefulness of these drugs, however, have not been finally determined. To mention a few, there is triethylene melamine (T E M). It is given intravenously or by mouth, preceding or following surgery or concurrently with x-ray therapy. The use of this agent requires careful hematological observation to detect leukopenia, bleeding, and bone marrow depression. This drug may best be reserved for the far advanced, inoperable, and recurrent cases. Hemisulfur mustard is structurally related to nitrogen mustard, but has less toxic effect on the blood, the

kidney, and liver functions. According to Seligman and Rutenberg this drug is more effective in treating metastatic ovarian carcinoma and ascites. Intraperitoneal radioactive colloidal gold in 150 to 200 millicuries dosage has been used with indifferent results in the control of ascites. Most cases, even those which appear clinically hopeless, should be explored. Some of the tumors are found to be benign, others with peritoneal implants and ascites may be benefitted by removal of some of the implants, the omentum, and as much of the primary tumor as is safe. This action may give temporary relief and make subsequent irradiation more effective.

The three major factors which influence prognosis are the histogenic origin, the histological degree of tissue differentiation, and the extent of clinical containment of the lesion. This latter appraisal is well demonstrated in the clinico-pathological classification of Turner, Remine and Dockerty.[24] The classification is as follows:

Stage 1: Comprises 22.7% of the cases. The tumor is cystic or solid, and confined to the ovary.

Stage 2: Comprises 21.5% of the series. Cases in which there has been a breakthrough of the capsule with infiltrated adhesions or with rupture of the capsule before or at operation. These cases often show bilateral involvement and pelvic metastases.

Stage 3: Comprises 30.2% of the group and reveals pelvic dissemination with involvement of the tubes, uterus, bladder, rectum and pelvic peritoneum.

Stage 4: Makes up 25.6% of the cases, and shows metastasis beyond the pelvis.

According to this classification, Stage 1, or 22.7% of the cases, is the only group in which we might expect satisfactory results.

Summary

1. Carinoma of the ovary is a formidable disease. 2. It occurs more frequently after the age of 40 years, and 70% of them develop before the age of 50. 3. Both ovaries are involved in 50% of the cases. 4. The overall 5 year cure rate varies from 20.3 to 30.4%. 5. The insidious onset of the disease in part accounts for the delay in the diagnosis, but both the patient and doctor contribute to this error. 6. The 40% inoperability at the time of exploration stresses the need for earlier diagnosis. 7. We can meet this challenge by better patient instruction, and by urging all physicians to include a bi-manual vaginal examination on all women patients regardless of their symptoms.

Bibliography

1. Abel, S. J., *Ovarian Carcinoma,* Mo. St. Med. Assoc. 54-423-429, 1957
2. Allan, M. S., Hertig, A. T., *Carcinoma of the Ovary,* Am. J. Obst. & Gynec. 58: 640653, Oct. 1949
3. Bruegge, C. V., Hobbs, J. E., Wegner, C. R., Wintemuth, R. W., *Bilateral Ovarian Metastasis from Renal Adenocarcinoma*: J. Ob. Gyn. 9, 1980205, 1957
4. Cowan 11, Feld, E. M., *Dysgerminoma of Ovary,* Am. J. Ob. & Gyn., 66, 668-673, 1953
5. Figge, D. C., DeAlvarez, R. R.: *Diagnosis Ovarian Carcinoma by Vaginal Cytology,* J. Ob. Gyn. 8, 655-63, 1956
6. Golub, L. J., *Diagnosis of Ovarian Cancer,* Am. J. Ob. Gyn., 66, 169-177, 1953
7. Green, Thos. H., Jr.,: *Hemisulfur Mustard in the Palliation of Patients with Metastatic Ovarian Carcinoma*: Obst. & Gynec., Vol. 13, April 59, P. 383
8. Kerr, H. D., Elkins, H. B., Am J. Roent. & Rad. Therapy, 66: 184-189, 1951
9. Kiettel, Wm. C., Elkins, H. B.,: *Experience with Radioactive Gold in the Treatment of Ovarian Carcinoma.,* Am. J. Obst. & Gynec., Vol. 71, No. 3, P. 553568, March, 1956
10. McGarvey, Richard N., *Cytological Diagnosis of Ovarian Carcinoma,* Obst. & Gynec., Vol. 5, No. 3, March 1955, p. 257-261
11. McGill, Jas. W., *Carcinoma in Children,* (Quotes Taussig), The Journal Lancet, Vol. 27, No. 5, P. 232, May 1952
12. Marchetti, Quoted by Randall, C. L., *Ovarian Carcinoma, Risk of Preserving the Ovary,* Obst. Gyn, 5:491-497, May 1954
13. Majewski, Quoted by West, Robt. H. : Quarterly Bulletin, Northwestern Univ. Med. School, 1955, 29: 256-57
14. Munnell, Equinus W., Jacox, Harold W., Taylor, Howard C.,: *Treatment and Prognosis in Cancer of the Ovary,* Am. J. Obst. & Gynec., Vol. 74, 1506, P. 1187-1200, Dec., 1957
15. Munnell, Equinus W., & Taylor, Howard C.,: Am. J. Obs. & Gynec. 58: 943-1949
16. Munnell, Equinus W., *Ovarian Carcinoma, Predisposing Factors, Diagnosis & Management, Cancer,* Vol 5, No. 6, Nov. 1952, P. 1128-33
17. Nichols, David H. & Portoloff, Anthony V.,: *Arrhenoblastoma of the Ovary,* N. Y. State J. of Med., Vol. 51, No. 15, Aug. 1, 1951
18. Parnanen, P. O., Vataja, Ylla. *Metastatic Ca. of the Ovary,* Am. Chir. et Gyn. Ferniae, 1954, 43: 327-331
19. Pedowitz, Paul & Grayzel, David M.: *Dysgerminoma of the Ovary,* Am. J. Obst. & Gynec., Vol. 61, No. 6, P. 1243-52, June, 1951
20. Peterson, Wm. F., Prevost, Edw. C., Edmunds, Frederick T., Hundley, Jr., J. Mason, and Morris, Frank K.,: Am. J. Obst. & Gynec. 1957, 71:173-189, Jan.
21. Randall, C. L., *Ovarian Carcinoma, (Risk of Preserving the Ovary),* Obst. & Gyn. 5: 491-497, May, 1954
22. Siddall, R. S. & Levine, Bernard, *Ovarian Tumor, Prophylaxis by Left Oophorectomy,* Am. J. Obst. & Gynec., 72: 1025-28, Nov., 1956
23. Sykes, M. P., Rundles, R. W., Pierce, V. K., Karrofsky, D. A., *Triethylene Melamine in the Management of far advanced Ovarian Cancer,* Surg., Gynec. & Obst., Vol. 101, 133-40, Aug. 1955
24. Turner, Jno. C. Jr., Remine, Wm. A., & Dockerty, Malcolm B.: Surg. Gynec. & Obst., Aug., 1959, Vol. 109, P.198-206
25. Wheelock, Frank C., Fennell, Robt. H. Jr. and Meigs, Joe V.: *Carcinoma of the Ovary, Clinical & Pathological Evaluation*: New Eng. J. Med., 245: 447-49, Sept. 20, 1951
26. Wolfe, Samuel A.,: *Metastatic Carcinoma of the Ovary*: Am. J. Obst. & Gynec. Sept. 55, 70: 563-571

CASE DISCUSSIONS
From The
University of Louisville Hospitals

Louisville General Hospital

Eclampsia with Postpartum Psychosis

L.G.H. Protocol #16169. P.W., a 17 year old single white primigravida, was admitted to Louisville General Hospital on June 3, 1963, after having had a convulsion. Her expected date of delivery as calculated from the menstrual history was July 27, 1963. She had not attended the prenatal clinic.

According to the patient's mother, the present illness began on the day before admission, when the patient complained of headache and weakness. On the morning of the day of admission, she was observed to have a generalized convulsion lasting about five minutes; during the convulsion, her eyes rolled upward, and she frothed at the mouth. There was no past history of convulsions or of any other illness.

On physical examination immediately after her arrival at the hospital, the patient was a young comatose girl who appeared to be in about the eighth month of gestation. A fetal heart beat was heard in the left lower quadrant, and was counted at 140. The blood pressure was 140/110. There was marked periorbital edema and extremely hyperactive deep tendon reflexes. Urinalysis showed 4-plus albuminuria. While the intern was performing the preliminary examination, the patient had a grand mal seizure. She was immediately given morphine sulfate, ½ gr intramuscularly together with 10 cc of 50% magnesium sulfate. She was then isolated in a dark room. An indwelling Foley catheter was inserted for collection of her entire urinary output. A regimen consisting of continued administration of morphine in dosage sufficient to maintain the respiratory rate at between 10 and 12 per minute was established, together with periodic administration of 50% magnesium sulfate.

Eight hours after admission, the total urinary output was only 100 cc. The deep tendon reflexes were still hyperactive, and 2-plus albuminuria persisted. The blood pressure was 130/98. On June 4, 1963, the day following admission, the blood pressure was stable at about 140/100, and the reflexes were less active.

On June 5, 1963, two days following admission, the 24-hour intake had been 2200 cc in the form of 5% glucose in water, while the output amounted to 1120 cc exclusive of the insensible loss. The blood pressure was now 170/110, and hyperreflexia persisted. Blood chemical determinations were as follows: sodium, 131 mEq/1; potassium, 3.8 mEq/1; CO_2, 18 mEq/1; blood urea nitrogen, 18 mg per cent; uric acid, 10.6 mg per cent.

On June 6, 1963, the third day following admission, there was slight apparent improvement. An attempt at induction of labor with Syntocinon was unsuccessful.

On June 7, the blood pressure showed wide fluctuations, reaching a maximum of 170/110. At 7:30 p.m., the membranes were ruptured artificially, and a dilute intravenous solution of Syntocinon was started. It was planned to deliver the patient by cesarean section if the induction attempt failed in the absence of any new contra-indicating complication. Before this point was reached, however, on June 8, the patient had three more generalized convulsions between 9:00 a.m. and 2:45 p.m. Large doses of morphine sulfate and magnesium sulfate were given in an effort to control the convulsive seizures, and the patient's respirations became extremely depressed, eventually reaching 8 per minute. During the afternoon, the patient fell into labor spontaneously, and at 8:16 p.m. she was delivered under local infiltration anesthesia of a living, viable male infant. The baby immediately breathed, and subsequently did well.

The postpartum course continued to be stormy. At 9:15 p.m., the patient had another tonic and clonic convulsion which responded to an intravenous injection of morphine. However, more convulsions occurred at 9:01, 9:10 and 9:17. The blood pressure had now risen to 190/130. An apresoline drip was started. At 10:50 p.m., the blood pressure plummeted to 100/60, and the pulse rate was 110; respirations were 7, and the temperature was 101°F. The patient was given Solu-cortef, 600 mg intravenously, and an infusion containing 30 million units of penicillin was started. Shortly thereafter, the blood pressure fell to 120/60. The apresoline drip was discontinued.

At 1:00 a.m. on June 9, the respiratory rate was 3 per minute. There had been no convulsion since 10:17 p.m. of the previous day. Caffeine sodium benzoate was given. At 7:45 a.m., the blood pressure was 140/90, and respirations were 8 per minute. The patient responded to stimuli, and began to be restless. The temperature was 98.6°F. Paraldehyde was given to control restlessness. Throughout the remainder of the day, the blood pressure was fairly stable at 140/100; the respiratory rate continued slow, and there was 4 plus hyperreflexia. On June 10, sedation was maintained with chloral hydrate. The patient was continued on high doses of penicillin and 100 mg Solu-cortef four times daily. She was awake

and alert; respirations were 20 per minute, and the blood pressure was stable at 140/90.

On June 11, 1963, the seventh day following admission and the third day following delivery, the patient was extremely fretful, confused and disoriented. The Babinski was positive bilaterally, and there was bilateral ankle clonus. The blood pressure was 160/120. A neurological consultant found only two cells in the cerebrospinal fluid after a lumbar puncture. A medical consultant thought the patient had diffuse brain damage due to anoxia. During the next five days, the steroid medication was gradually reduced. The patient improved physically, but became withdrawn and unresponsive, and seemed confused and disoriented.

On June 17, she was transferred to the psychiatric service, and further history was obtained. The patient had shown symptoms of extreme withdrawal from time to time prior to the acute toxemic episode. She had also been deeply impressed by her father's disapproval of the illegitimate pregnancy of a sister, and had steadfastly denied any knowledge of her own pregnancy. On the basis of a working diagnosis of undifferentiated schizophrenia, the psychiatric staff recommended electroshock therapy. After three shock treatments, the patient was rational and responsive, and displayed a reasonable amount of insight into her situation. Her physical findings had all returned to normal by June 29, 1963, and she was discharged from the hospital shortly thereafter.

Discussion

Douglas M. Haynes, M.D., professor and chairman, department of Obstetrics and Gynecology, University of Louisville School of Medicine.

This case illustrates an instance of the eclamptic phase of the preeclampsia-eclampsia syndrome of such severity that the survival of the patient must be regarded as a fortunate but unexpected outcome. The cardinal principles involved in the treatment of convulsive toxemia are (1) control of the convulsions, and (2) emptying of the uterus after such control has been attained. In the patient in question, usually effective means of securing control of the convulsions failed to do so until she had had eight seizures; fortunately, spontaneous labor and delivery supervened, as failure to control the convulsions prevented cesarean section following failed induction of obligation. The anticonvulsant action of morphine, usually highly effective in eclampsia, was not impressive in this patient despite marked reduction in the respiratory rate. The acute hypertension displayed by this patient responded quite dramatically to a hypotensive agent, in this case apresoline, but the picture was confused by sudden hypotension developing in the presence of fever and tachycardia, clinical findings which suggested the superimposition of a septic shock syndrome. In retrospect, it is doubtful that this patient actually had septic shock; but the steroid therapy which was started when this diagnosis was entertained was a further complication of the entire picture, requiring gradual withdrawal in order to avoid iatrogenic shock.

The patient's postpartum disorientation may have been at least partly due to cerebral anoxia; in any event, any central cerebral changes were clearly reversible in view of her recovery. The possibility of an underlying schizophrenic tendency could not be evaluated during the acute episode because the patient was comatose when she was first seen and the history obtained under the circumstances of admission was somewhat sketchy. Later, the underlying conditions of a postpartum psychosis proved to be present in this patient's personality and environment, and it is not surprising that overt psychotic behavior was precipitated by the extreme stress of the nearly fatal eclamptic episode. It should be emphasized that eclampsia *per se* would not be expected to precipitate such a psychotic episode in the absence of preexisting personality traits which would predispose the patient to development of psychotic behavior. Rather, the overwhelming toxemia probably served as a nonspecific stress which, in turn, precipitated the psychosis.

Be Sure to Attend

The First Kentucky Congress on Mental Health

Thursday, May 14

Kentucky Hotel—Louisville

SPECIAL ARTICLES



Richard Geist, a senior medical student at the University of Kentucky College of Medicine, is shown examining an Iranian child, one of many he helped to treat as a part of his medical clerkship this year in Iran. Geist was one of five senior students selected to take part in the University's first year of its permanent International Community Medicine Clerkship program. The program is the only one of its kind in U.S. medical colleges.

Kentucky Medical Students Abroad

THIS year the department of Community Medicine in the University of Kentucky College of Medicine launched a unique teaching program in cross-cultural medicine. Five carefully selected senior medical students spent from twelve to fifteen weeks overseas in Iran, Jamaica and Colombia where, under the supervision of local faculty members they gained experience in carrying out clinical and preventive medicine, in conducting a community health study and in organizing an epidemiologic project in circumstances far removed from those in Kentucky.

At the end of his International Community Medicine Clerkship the student has considerable insight into the health problems of a developing country and becomes aware of the many social, economic, political and cultural factors influencing these problems. No other medical school in the United States has a program in international medicine similar to these clerkships which, with the increasing demand for physicians with an understanding of international health problems, is to become a permanent part of the curriculum of the U. K. College of Medicine.

Richard Geist, in the following article, tells of his experiences in Iran.

ANTHONY ADAMS, M.D.*

*Director, International Community Clerkship Program, department of Community Medicine, at the University of Kentucky College of Medicine, Lexington, Kentucky.

International Community Medicine Clerkship 1963-64

Iran

RICHARD E. GEIST*

Lexington, Ky.

Iran is a large middle-eastern country covering some six-hundred thousand square miles, or about half the size of the United States. It has an estimated count of twenty million people.

Shiraz is a city one hundred-and-fifty miles north of the Persian Gulf. It is one of the oldest cities of Iran, with a history going back at least two-thousand and two-hundred years. Now the capital of the Fars Ostan (Province) where the Persian Language originated, Shiraz was the home of the famous poets, Saadi and Hafiz. In the sixteenth century A.D., Shiraz was the capital of the Persian Empire.

Climate has played a major role in the development of the area. In the time of Darius, (518 B.C.) the surrounding countryside was reported to be the richest in the world, with vegetation and more than enough food to support the existing two million people around Shiraz and Persepolis. In recent years the area around Shiraz has been used entirely for agriculture and pasture lands, but for the past five years the land has suffered partial drought and it is now barren and dusty, barely supporting its inhabitants.

The economy of Iran is based mainly upon agriculture, with major crops of tea, wheat, rice and fruit. The oil deposits in southwestern Iran, centered at Abadan, provide large royalties to the government, as do export items of carpets and caviar.

The people may be divided into three groups—the tribes, the villagers and the city dwellers.

The tribal people comprise one of the largest migratory groups in the world. Seldom in one place for more than a few weeks, these nomadic people wander with the seasons, north and south over routes their ancestors traveled for hundreds of years. Originally, these people migrated from Turkey over two-thousand years ago into Persia and brought with them their Turkish dialects, customs and dress. Despite repeated contact with the Persian culture for this length of time, they have maintained themselves as a separate unit and a separate culture, speaking "Turki". They are tightly organized groups usually living in family and group units of five to ten tents, led by an all-powerful chief, the Khan. Each family unit is a part of a larger organization, a sub tribe which in turn comprises a tribe. There are eight to ten major tribes in Iran; the one centered around Shiraz was the Ghashghay tribe of about forty-thousand people.

The tribal people are a hardy, independent and self-sufficient society. They usually have herds of sheep and goats for food and milk, and their migration is often determined by the availability of water and grazing land. They are rarely in one place long enough to raise crops. sometimes they trade livestock or handmade items, such as rugs or cloth, for grain and rice. They live in tents made of goats' hair woven into a black burlap-like material and these are always strikingly obvious as black spots on the grey-white dusty terrain.

For most of the tribesmen, we were the first medical people to be seen. Only the seriously ill might have seen a doctor if they happened to be located near a town at the time of the illness. People unable to travel were a serious handicap and would have to be carried by the pack animals. Each tribe had developed its own beliefs and cures for disease. One of the most common was that of wearing a small cloth bag containing a blue turquoise tied around the neck to ward off the "evil eye".

The village people comprise the largest population group in the country, and they are widely scattered across the plains. each village is a self-sufficient unit of one-hundred to several thousand inhabitants. The villages are usually isolated, with no means of communication and few or no connecting roads with surrounding areas. Many of these villages have existed for hundreds of years and their way of life has changed very little. Each village is enclosed within a fifteen to twenty foot high mud and brick wall with a single gate entrance, originally designed to keep out bandits. In isolated areas the people and herds are locked inside at night for protection. The houses are made of mud, straw and bricks with thick walls, and no windows, to keep out the summer heat. The family group has its own walled-off area within the village where the personal cattle and private gardens are kept. Villages are ruled by the Kadkhoda or chief, who is often the richest man present. The land surrounding each village is used for farming and grazing; water comes from nearby streams or long established wells within the walls.

The government's land reform program, begun five years ago, takes the villages from the landowners without compensation and redistributes portions of the land to the individual farmer. After several years of operation, only a small percentage of villages have been redistributed and those lands that have been given back to the farmers, in many cases, have remained unused because they have no capital for grain, no skill, and no equipment to care for the land. Cooperative efforts in the villages would seem to be the answer, but few villages have tried. One good example of cooperative village enterprise is a village near Kazeroon, southwest of Shiraz. The men

*Senior medical student at the University of Kentucky College of Medicine.

have been out of work several years, due to drought and land reform, so the local school teacher organized the men to dig a well near the village, install a small pump, and irrigate a large area. On this, they raised melons for sale in town, the profits going to each worker.

Some of the men are able to obtain jobs in nearby towns, doing manual labor in a few factories. In every case they must travel long distances on foot, donkey or bicycle. Others try to raise crops or tend herds, but until the drought is ended, this will barely provide subsistence living. The village women, dressed in traditional Islam-dictated chadoors, or head-to-toe drape, are usually busy tending the children, cooking, washing clothes, and occasionally making carpets. The boys, ten to fifteen years old, must tend the herds daily, while the girls must help the mother. Marriages are early and most girls are married by the time they are sixteen. The younger girls are responsible for the care of the babies, and the younger boys may go to school. In one village where we worked, I watched a four year old girl collecting the feces of donkeys, packing it into balls which she placed in the sun to dry, to be used for cooking and heating fuel. Then she washed her hands in the family's shallow drinking well.

Medical Care

Medical care in the villages is more common than in the tribes, but it is still not easy to obtain, mostly for geographical reasons. The cities and towns have most of the doctors. The villagers travel many miles to a doctor or one of the public health clinics. Some of the larger villages have behdors, a trained midwife, who dispenses medicine and who can recognize the seriously ill. Unfortunately, the majority of practicing midwives have had no formal training at all. Other villages have Behgors, who are trained in medical schools for three or four years out of a six-year program, and then sent to extern in a rural area for one to two years. These students are often without supervision or clinical experience, but they are called upon to handle all village health problems. The more severely ill are referred to the nearest hospital, but due to the scarcity in transportation, many do not make the trip.

The villages are also served by traveling immunization teams giving D.P.T. and smallpox vaccinations to all who will take them. There is a T.B. team giving BCG on the same basis. In the southern sections where malaria had once been a severe problem, the Ministry of Health instituted an eradication program which required each house of every village to be sprayed twice a year and the case rate has dropped over fifty percent in the past five years. Other public health measures, such as food and water sanitation, traveling clinics and infectious disease follow-ups, are slow to develop. The midwives are encouraged to take courses from public health departments, and Shiraz has a good Behgor school, but the problems of inadequate numbers of trained personnel, money and equipment, make progress slow for Iran.

The city people are a mixture of villagers, tribesmen, merchants and laborers, but most of the city people have lived in the same area for generations. Only in recent years, with new industry and mechanization, have men and families moved from villages into cities seeking jobs.

The people live in low, thick-walled houses, some of straw and mud, but many of brick. Shiraz is fortunate in having one of the few treated, piped water systems in the country, which supplies over half the city with subscription service, and free spigots in the underdeveloped areas of the city. The cities still have extensive systems of jubes, which are three feet deep cement water troughs on both sides of the streets, resembling sewers. These interconnect in an intricate system throughout the city, and one or more is continually full of running water fed by a spring outside the city. This water is used for animals, washing clothes, bathing children, dumping garbage, watering plants, as well as a play pool for children on hot days. An old Persian belief is that running water is pure, and consequently people are not afraid to drink the same water.

Medical care in Shiraz is a relatively easy matter since there are a number of doctors and specialists as well as public health clinics, hospital clinics and hospitals available. The cities have pharmacies that dispense most of the common drugs. In Kazaroon, a city of seventy thousand southwest of Shiraz, there are four physicians for an estimated area population of seven-hundred-and-fifty-thousand.

My local supervisor, Doctor Mehra, is the Director of Nemazee Hospital in Shiraz and Chairman of the Department of Preventive Medicine at Pahlavi Medical School. Under his direction, I was assigned to the U.S. AID health team under Bruce Jessup, M.D., a Californian pediatrician, who was on a two-year Public Health assignment in Shiraz. When I arrived he was just organizing a village and tribal survey in the area, to determine what the health status of these populations might be. Very little statistical work had ever been done here, and the previous health programs had been based on very little factual data. I was asked to join this survey, which had been in the planning stages for several months.

I became particularly interested in the nutritional problems of these people. For the survey I set up a nutritional examination program to determine the prevalence of clinically detectable nutritional diseases among the children. I examined all of the children in the study groups under twelve years of age, checking height, weight, biceps size, subcutaneous fat, pallor, hair and skin changes, liver or spleen enlargement, edema or ascites, as well as a general examination for other diseases or pathology. At the same time we conducted general medical clinics; our laboratory teams took blood from everyone for hemoglobin, hematocrit, serum proteins, thin smears for counts and thick smears for malaria, stool for ova and parasites, urine and hair samples for zinc studies, Casoni skin tests, and cultures as needed. Specially trained medical students and midwives talked to each family involved, getting detailed family history of disease, births, deaths, foods, economy and practices, while others did psychometric examinations, for in-

telligence and mental illness, by coin tests, block designs, Z-test, and open-ended sentences.

The village and tribal work consumed the major part of two months. We studied three village groups south of Shiraz. Prior to starting our work, the public health department in Shiraz sent a sound-truck to the village, a day or two before we arrived, explaining what was going to happen and asking their cooperation. At the same time, they usually presented a movie in Farsi, on some public health topic, such as diptheria immunizations or sanitation, which was always well-received. While our group was actually working in a village, we offered free medical care to all its inhabitants.

In my survey examinations I encountered many types of disease in addition to those for which I was looking. The most common diseases in children were purulent conjunctivitis (20% in one village), draining otitis media, impetigo, favus, and gastroenteritis. Other conditions included congestive heart failure, mitral stenosis, pilonidal cysts, and sinuses, inguinal herniae, residual polio, congenital syphilis, severe uncorrected clubbed feet, mongolism, and typhoid, upper respiratory infections, etc.

After the initial census and house-to-house family interviews, the team worked in four parts: the psychological testers, the laboratory, the clinic and treatment team, and my pediatric examinations.

I gradually picked up a few words and phrases sufficient to direct patients and catch the drift of the reply, but this was toward the latter part of my stay. Everywhere I set up my examinations, a crowd gathered, standing or squatting around me, watching cosely. In a few minutes the men would see the pattern of my examinations and would then direct the children for me in the necessary movements. The women, a suppressed group in Iran, would sit quietly on their haunches and rarely speak to me, but they would comment among themselves about anything unusual I might do. If I looked at them or addressed them directly, they would shy away, giggle or leave. The children, brought to me when we first entered a village, would be boys and then the girls later, and finally the babies. The girls, young and old, were shy about exposing even their abdomen for examination. The older girls (ten to twelve years) had to be examined through or under their garments, or a great uproar would come from the always present mothers. In general though, the people were very tolerant of our examinations and tests, and we encountered little difficulty.

The results of my nutrition examinations revealed three cases of frank malnutrition, all marasmus, and two borderline cases, so there were then five per three-hundred-and-eighty-five, or 1.3 percent malnutrition in children in the study group of twelve years and under.

During a lull in the survey, I took two Pahlavi medical students studying Public Health to the smaller city of Kazeroon, a three-hour drive southwest from Shiraz. Our purpose was to do a community health study of the area according to the World Health Organization's "Outline of Local Health Study". During this time we visited the local doctors, hospital, clinics, malaria control center, nearby villages and met the local officials. We were received very cordially and our survey was hindered only by the lack of available records and statistics for the area. I was most impressed by the malaria control unit in Kazeroon. Their initial results were most rewarding, but the mosquitos have gradually become resistent to DDT. However, they had just developed a new spray for current use which seemed promising.

In my other spare time I worked in the public health clinic in the depressed area of Shiraz and one of the small towns north of Shiraz.

On the wards of Nemazee Hospital I saw and examined many cases that I might never have seen elsewhere, such as typhoid, diptheria, visceral and cutaneous anthrax, kwashiorkor, marasmus, amoebiasis, and many others. I was again impressed with the number and severity of malnutrition cases on the pediatric service. This stimulated me to review the literature and existing records of all the patients admitted to the pediatric service with the diagnosis of malnutrition. There were two-hundred-and-seventy-seven cases in all, with a case fatality rate of 27.1 percent! These cases represented ten percent of the pediatric inpatient admissions and forty-nine percent of them had gastroenteritis as a complication. Malnutrition in Iran has rarely been mentioned in the medical literature, and the official government position, at least until this year, was that it was not a problem. In October, 1963, I was able to attend the Annual National Medical Convention held in Ramsar, on the Caspian Sea 150 miles northwest of Tehran, which devoted its entire conference to problems of nutrition, and there I was asked to present a summary of my findings of the Namazee study to point out the magnitude of malnutrition in southern Iran.

EDITORIALS

Kentucky Program on Medical Aspects of Driver Limitation

ON January 1, 1964, the Department of Health, the Department of Public Safety and the Kentucky State Medical Association jointly activated a pioneering program on medical aspects of driver limitation. Initial studies began June 1961, and formative steps were detailed in a Special Article in this journal (JKSMA 61:591-2, July 1963). An informational "Statement of Position" has been issued by KSMA (3rd Revision, January 1964) in response to inquiries from dozens of other states and agencies.

Principles and mechanics of this program were approved by the AMA Committee on Medical Aspects of Highway Safety, March 1963; the trustees of the AMA, November 1963; and the AMA House of Delegates, December 1963, as a prototype or suggested model program (J.A.M.A. 187:376, February 1, 1964). Similar encouragement has come from highway safety committees in Iowa, North Carolina, Texas, and Virginia (Va. M. Monthly 90:611-8, December 1963).

Medical examination for driver limitation will now be ordered by state police or the Division of Driver Licensing when a driver (1) is involved in three traffic accidents within 24 months (subsequent to initiation of this program), (2) volunteers that he "blacked out", didn't know what happened, or has contributing medical problems, (3) displays obviously impaired abilities, or (4) is believed, on the basis of a sworn affidavit, to have physical or mental deficiencies, making him potentially unsafe to drive.

Such an individual will be notified by letter from the Division of Driver Licensing to appear before a physician of his own choice (at his expense) or the nearest county health officer (at no cost) within 45 days of such notification. A "Medical Report" will be completed by the individual, answering questions on medical and accident history (Section I: pages 1 and 2) and the physician accomplishing Section II (pages 3 and 4). The physician will mail the completed four-page report to the Department of Health, Division of Accident Prevention, Frankfort, and an attached postcard to the Division of Driver Licensing, indicating that examination has been made.

The "Medical Review Board" composed of five physicians (selected by the Commissioner of Health from nominations made by KSMA Trustees) will periodically meet to evaluate such cases and advise the Division of Driver Licensing concerning the maintenance, suspension or restriction of driving privileges. The Division of Driver Licensing will then notify the individual; if desired, he may appeal such decision and submit additional data. The case will then be mailed, by number designation only, to an anonymous "Appeals Board" of nine physicians selected as above. This board may request additional examinations (EEG, ECG, etc.) or reply directly on the information submitted.

Driving privileges will *not* be suspended unless or until (1) 45 days have elaspsed and the individual has not reported for examination, or (2) The Reviciw Board has by majority vote recommended suspension, or (3) actions returned in appeal to the Division of Driver Licensing have been decided by a majority vote of the Appeals Board.

Establishment of this program is one of three major goals of the Highway Safety Committee at this time. The seat belt program, begun in Spring 1961, seems to be progressing under good momentum but still requires emphasis. The third goal of achieving significant safety design modification of vehicles has been accelerated by formal action of three bar groups within our state to present a firm medical and legal front to the manufacturers.

ARTHUR H. KEENEY, M.D., CHAIRMAN*
Highway Safety Committee
Kentucky State Medical Association

Other members of the committee are: Herald K. Bailey, M.D., R. Arnold Griswold, M.D., William K. Keller, M.D., John J. Robbins, M.D., William T. Rumage, Jr., M.D., and Claude W. Trapp, Jr., M.D.

Charity Begins At Home

THROUGHOUT the United States the County Society is the basic unit in organized medicine. Every county in Kentucky, whether represented by one physician as is the case in six, by 141 in the Campbell-Kenton group, 275 in Fayette, or 781 in Jefferson, has equal opportunity as a delegate or delegates to present before the governing body of our State Society such constructive opinions or resolutions as they feel appropriate. These are considered deliberately by representatives of the entire state organization and if regarded with favor, are put in the hands of our three elected delegates for presentation to the governing body of the American Medical Association.

From such opinions or resolution initiated in the County Societies of the entire country come the guiding policies of our professional conduct and our relation to the general health care of our people.

In the present generation the interest and function of the County Medical Society has undergone constant evolution. No longer is it a unit solely for the exchange of medical knowledge and the dissemination of health information. Increasing demands and obligations for participation in political and economic affairs have required a shift from scientific activities toward social concern of national and world wide interest.

The medical profession has not suffered but has profited by the acceptance of a wider field of responsibility. The increase in the number of general and specialized societies for exchange of medical knowledge on a state and national basis, the formation of smaller groups of physicians for discussion in specialized fields, the expansion of hospital staff activities, have provided a much richer and more diversified source of scientific information than was ever possible through the County Societies alone.

The larger County Societies in the State have engaged in a great variety of enterprises the intent of which is constructive and progressive even though at times accomplishment may fall short. It has been customary to invite at rather frequent intervals distinguished men in medicine and allied fields to bring to the members a new insight into a variety of constructive endeavors. Attention has been given to the development of Medical Assistants' Societies for the general improvement of office care and private practice. Business bureaus have been organized with the end in view that the physician's financial activities should be conducted on a plane of dignity consistent with our profession.

Speakers bureaus have been established from which interested civic, church or other groups may obtain freely the medical professions' views on affairs which interest the general public. Programs of continuing education are sponsored, providing in one center a rich source of information, or carrying such information when desired to the smaller and more remote areas of our state. Attempts are being made to more closely coordinate the interest of full time teachers and administrators in our two medical schools with the activity of the practitioner. A number of merit scholarships have been provided in order to keep in our own schools our sons and daughters of exceptional talent, and to attract students of high scholarship from elsewhere.

These diverse activities of our county medical societies have required the diligent application of a great number of men as committee members. It is inspiring to find them in various groups assembled on what would ordinarily be their day off or late into the night attempting to contribute their part.

The physician who aims to carry on the best traditions of our profession cannot do so by the single-minded pursuit of private or institutional practice, teaching, or research. He owes something to the collateral activities under discussion. He will be happier when, with his colleagues, he has discharged to the best of his ability these additional obligations.

SAM A. OVERSTREET, M.D.

ORGANIZATION SECTION



Doctor Hamwi



Doctor Shaffer

Trans-Atlantic CPC Highlight of KSMA Annual Meeting

A Trans-Atlantic telephone clinicopathological conference between leading obstetricians and gynecologists here and in England will be one of the highlights of the 1964 KSMA Annual Meeting, according to George P. Archer, M.D., Prestonsburg, KSMA president.

Subject of the Trans-Atlantic link on Tuesday, September 29 will be "Toxemia in Pregnancy". Douglas M. Haynes, M.D., Louisville, program chairman for this year's meeting will moderate the panel here. Participants in England will be members of a new postgraduate teaching unit at Kingston Hospital, Kingston-upon-Thames, Surrey.

Doctor Archer said that this year's overall program, including the Trans-Atlantic Link, should be one of the finest ever presented. Site of the September 28 through October 1 meeting is the Convention Center in Louisville.

Names and information on two guest speakers who will speak at the meeting were announced by Doctor Archer at press time. Both are faculty members of the College of Medicine, Ohio State University.

George J. Hamwi, M.D., Columbus, Ohio, guest of the Kentucky Chapter, American College of Physicians, will give a talk on "Nibbling and Gorging" at the general session on October 1. His talk at the specialty group session on September 30 will be "Insulin Resistance and Insulin Antagonists".

Doctor Hamwi, a graduate of the American University of Beirut with an M.D. degree in 1940, is professor of medicine and director of the Division of Endocrinology and Metabolism at Ohio State University. He is also director of the Ohio State University College of Medicine Department of Clinical Research. A native of New York City, Doctor Hamwi is a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians, and a member of the Board of Directors of the American Diabetes Association.

Guest of the Kentucky Pediatric Society will be Thomas E. Shaffer, M.D., Columbus, Ohio, whose topic at the general session on October 1 will be "Some Problems in High School Athletics". Doctor Shafer is director of medical services at the Juvenile Diagnostic Center of the Ohio Youth Commission and is professor, department of Preventive Medicine in the College of Medicine of Ohio State University.

He is a 1932 graduate of Cornell University Medical College. Doctor Shaffer is a fellow of the American Academy of Pediatrics, American College of Sports Medicine, and the American Public Health Association. He is a diplomate of the American Board of Pediatrics and serves on the AMA Committee on Medical Aspects of Sports. He was in the Army Medical Corps from 1942-46. "The Adolescent and Your Practice" is the subject he will cover before the Kentucky Pediatric Society on Wednesday, September 30.

Preliminary Program Released For 1964 Annual Meeting

The preliminary program outline for the 1964 KSMA Annual Meeting, to be held September 29—October 1 at the Convention Center in Louisville, has been released by George P. Archer, M.D., KSMA president and chairman of the Scientific Program Committee.

Further information on speakers and their topics will be published in later issues of The Journal. The tentative basic program follows:

Tuesday, September 29

Morning Session

Noble O. Fowler, M.D., Cincinnati, Ohio
Topic to be announced

George P. Archer, M.D., Prestonsburg, Kentucky, KSMA President
President's Address

George R. Prout, Jr., .D., Richmond, Virginia
"Renal Homotransplantation in Modified Recipients"

Ronald Stephen, M.D., Durham, North Carolina
Topic to be announced

John R. McDonald, M.D., Detroit, Michigan
"Current Theories of Carcinogenesis"

Afternoon Session

Trans-Atlantic Telephone Medical Conference

Douglas M. Haynes, M.D., Louisville, Moderator

Leon J. Warshaw, M.D., New York, New York
"Cardiacs Can Work"

Kenneth R. Byerly, Chapel Hill, North Carolina
"The Physician and the Press"
Trawick H. Stubbs, M.D., Atlanta, Georgia
Topic to be announced

Wednesday, September 30

Morning Session

Alton Ochsner, M.D., New Orleans, Louisiana
"Treatment of Metastatic Lesions of the Lung"
H. R. McCarroll, M.D., St. Louis, Missouri
"The Diagnosis and Clinical Management of Congenital Dysplasia and Congenital Dislocation of the Hip in Infancy"
Arthur M. Mickler, D.M.D., Louisville, Kentucky
"Dental Problem in Children"
Elsie Reid Carrington, M.D., Philadelphia, Pennsylvania
"Endotoxic Shock in the Obstetric Patient"

Afternoon Session

Several specialty groups will hold their meetings during the Wednesday afternoon session. No general scientific session is planned for that time.

Thursday, October 1

Morning Session

Miles L. Lewis, Jr., M.D., New Orleans, Louisiana
"The Problem of the Dizzy Patient"
Emerick D. Szilagyi, M.D., Detroit, Michigan
Topic to be announced
George J. Hamwi, M.D., Columbus, Ohio
"Nibbling and Gorging"

Diabetes Symposium

Robert S. Tillett, M.D., Louisville, Moderator
Participants:
Thomas E. Shaffer, M.D., Columbus, Ohio
Elsie Reid Carrington, M.D., Philadelphia, Pennsylvania
George J. Hamwi, M.D., Columbus, Ohio
Emerick D. Szilagyi, M.D., Detroit, Michigan

Afternoon Session

Athletic Injury Symposium

Participants:
Thomas E. Shaffer, M.D., Columbus, Ohio
"Some Problems in High School Athletics"
O. B. Murphy, M.D., Lexington, Kentucky
"Conditioning for Sports"
Question and Answer Session

13th District Hears Dr. Archer

George P. Archer, M.D., KSMA President, spoke at the Annual Meeting of the 13th Trustee District Tuesday, March 17, at the Bellefonte Country Club in Ashland. Clyde C. Sparks, M.D., KSMA Trustee for the District, introduced the KSMA President.

Master of Ceremonies for the evening was William Schnitzker, M.D., President of the Boyd County Medical Society. A total of 75 physicians and wives attended the meeting.

W. Leon Hisle Will Head Hospital Assn. in '65

W. Leon Hisle, administrator of Berea College Hospital since 1957, was named president-elect of the Kentucky Hospital Association April 2, during the KHA's 35th annual meeting in Louisville.


Mr. Hisle

Ben R. Brewer, administrator of Western Baptist Hospital in Paducah, was installed as 1964 president at the annual dinner meeting on Wednesday, April 1.

Milford O. Rouse, M.D., Dallas, Tex., speaker of the American Medical Association's House of Delegates, and George P. Archer, M.D., Prestonsburg, KSMA president, were among the featured guest speakers during the four-day session.

Also on the program were Charles C. Edwards, M.D., Chicago, assistant director of the Division of Environmental Medicine and Medical Services of the AMA, and James B. Holloway, M.D., Lexington, chairman of the KSMA Hospital Committee.

Sander Vanocur, former NBC News White House Correspondent, was the main speaker at the President's Luncheon marking the formal opening of the convention.

The new president-elect of the Hospital Association received his B.A. degree from Centre College, Danville, Ky., in 1949, and completed a two year post graduate course at Duke University School of Hospital Administration in 1957.

Within the KHA, Mr. Hisle has served as a member of the Board of Trustees, chairman of the Council on Association Services, chairman of the Committee on Nursing Homes, and of the State Safety Committee. He was secretary-treasurer of the Bluegrass Hospital Conference in 1960, president-elect in 1961, and president in 1962.

Ninth Trustee District Schedules Meeting

Nearly all KSMA Trustee District meetings have now been scheduled. Invitations containing detailed information are being forwarded to members in each District approximately 4 weeks prior to their meeting.

On June 3, the 9th District will meet in Paris, beginning with a social hour at 5:00 p.m. Dinner will be at 6:00 p.m. at the hospital. Mitchel Denham, M.D., Trustee for the District, announced that George Archer, M.D., KSMA President, will be the featured speaker at the evening session. Wives are invited and urged to attend.

Other District meetings scheduled for May which have been previously reported in Journal of KSMA include: the 6th District on May 12; the 12th and 15th on May 13; the 3rd on May 28; the 4th on May 14; the 7th on May 21; the 2nd on May 26; and the 1st on May 27. The 8th District will meet June 4.

Dr. Schuler Pres.-Elect Of Ky. Dental Assn.

Thomas H. Schuler, D.D.S., Covington, was chosen president-elect of the Kentucky Dental Association during the April 4-8 annual meeting of the KDA at the Brown Hotel in Louisville.



Doctor Schuler

Doctor Schuler will take over the office of president in 1965 from R. Burke Coomer, D.D.S., who was installed as president at the April meeting.

Other officers who were elected at the same session are M. G. Randall, D.D.S., Louisville, first vice-president, and W. H. Washburn, D.D.S., Beaver Dam, second vice-president. A. B. Coxwell, D.M.D., Louisville, is currently secretary-treasurer of the association.

Doctor Schuler, a general practitioner, received his D.D.S. from the University of Louisville School of Denistry in 1937. A past president of the Northeastern Dental Society, he is a member of the Executive Board of the KDA, and of the Technical Advisory Committee for Medical Care of the Indigent.

He is a member of the State Legislative Committee of the KDA, the House of Delegates of the KDA, and the Dental Trade and Laboratory Relations Committee. Doctor Schuler saw service in the C.B.I. Theatre as a Major in the Army Dental Corps during World War II.

Five Kentucky M.D.'s Appointed To AMA Committees

The American Medical Association has appointed the following KSMA members to serve on AMA committees during the coming year.

Arhtur H. Keeney, M.D., Louisville, has been reappointed a member of the Committee on Medical Aspects of Automotive Safety, a group whose aims are to inform the profession, the public, and automotive manufacturers of factors in automobile safety.

Owen B. Murphy, M.D., Lexington, was reappointed to the Committee on Medical Aspects of Sports, which advises athletic personnel on phases of health supervision of sports and gives interested physicians information on the application of medical skills in the athletic setting.

Newly appointed to the Committee on Nursing is Edmund D. Pellegrino, M.D., Lexington. The primary purpose of this group is the maintenance of high standards of patient care in the preventive, curative and restorative aspects of illness.

Nicholas J. Pisacano, M.D., Lexington, is a new member of the Committee on Rehabilitation, whose function is coordination of the AMA's interest in rehabilitation and the dissemination of information to physicians on various aspects of rehabilitation.

William T. Rumage, Jr., M.D., Louisville, was reapointed to the Committee on Disaster Medical Care of the Council on National Safety. This committee is responsible for assisting state and federal civil defense authorities, military departments, and USPHS with medical and health problems, and acts as a liaison with allied health agencies in time of war or national emergency.

Dr. Massie Honored by Surgeons

Francis M. Massie, M.D., clinical professor of surgery at the University of Kentucky College of Medicine, was elected April 3 as the first Senior Fellow in the 86-year history of the American Surgical Association, during the group's annual meeting in Hot Springs, Va. Doctor Massie is a past president of the Southern Surgical Association and the Fayette County Society.

Dr. Brown Installed As Public Health Head

Buster F. Brown, M.D., M.P.H., Frankfort, was installed as president of the Kentucky Public Health Association on April 16 at the close of the association's annual meeting in Louisville.



Doctor Brown

Named president-elect of the association was William S. Pickett, Elizabethtown, administrative assistant in the Hardin County Health Department. Mr. Pickett has been in health work for 35 years. New vice-president-elect is William S. Wester, executive assistant in the State Health Department in Frankfort.

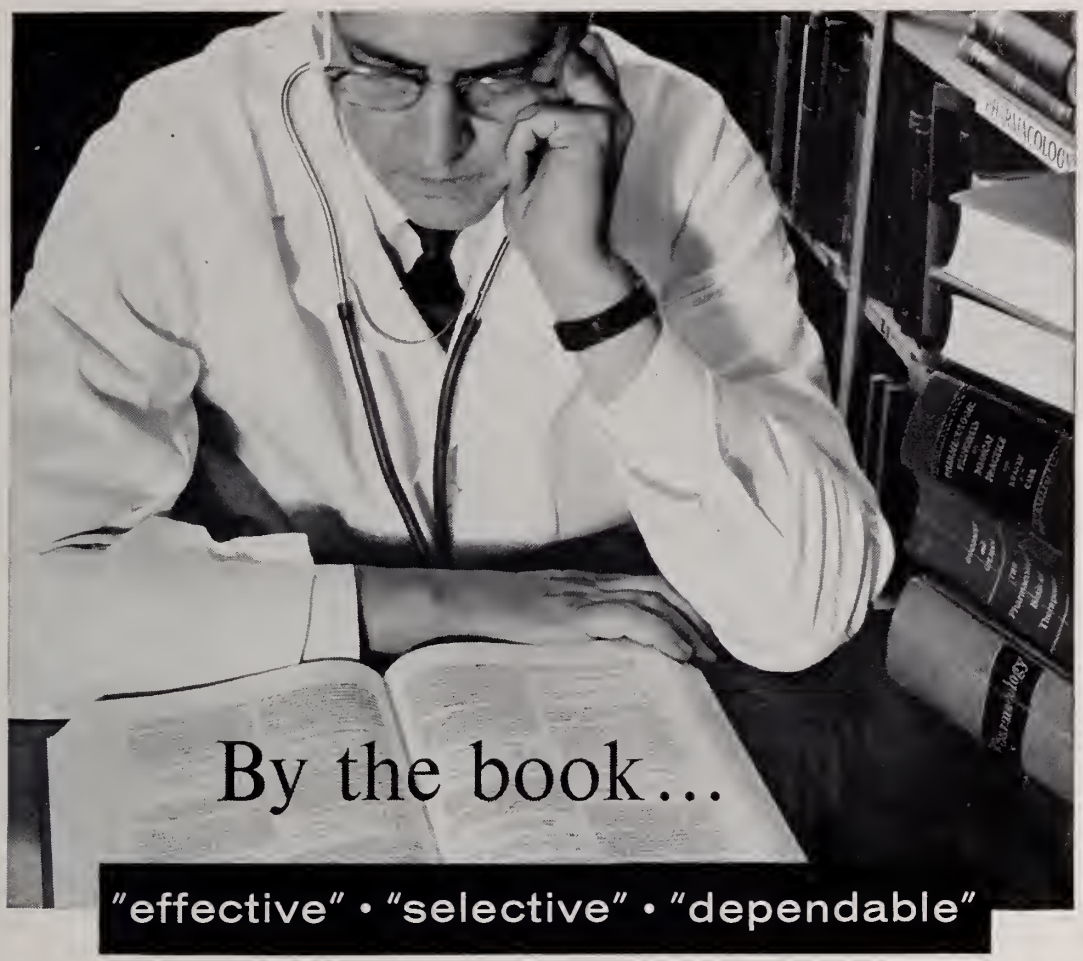
Doctor Brown, director of the Division of Laboratory Services for the Kentucky State Department of Health, is a 1953 graduate of the University of Louisville School of Medicine. He received his Master's degree in public health from the University of North Carolina School of Public Health in 1961.

Doctor Brown holds memberships in many medical organizations, including the AMA, the KSMA, and the Kentucky Association of Public Health Physicians, of which he is president.

Prior to accepting his current position with the State, he was in general practice at Harrodsburg, and from 1957-1960 served as health officer for Daviess, Hancock, and McLean Counties. From 1954-1957 he was a Medical officer in the U.S. Navy.

Dr. Witten Re-elected by AAGP

Carroll L. Witten, M.D., Louisville general practitioner, was elected April 13 to his fifth term as speaker of the House of Delegates of the American Academy of General Practice at the AAGP's 16th annual Scientific Assembly at Atlantic City, N. J.



PRO-BANTHĪNE®

BRAND OF propantheline bromide

For Ten Years... the Standard Anticholinergic

Many studies by many investigators over many years have established Pro-Banthīne (propantheline bromide) as the standard anticholinergic in the management of peptic ulcer and other gastrointestinal disorders.

It Is Effective—Hundreds of comparative laboratory and clinical trials and innumerable gratified patients have made Pro-Banthīne (propantheline bromide) the most widely-prescribed medication in its class.

It Is Selective—Its major effect is on the gastrointestinal and urogenital tracts. Secondary activity when noticeable seldom passes the point of temporary annoyance.

It Is Dependable—Moderate doses reduce gastric secretion and acidity and diminish gastrointestinal hypermotility. The usual dosage may be safely doubled or tripled to suppress symptoms in patients with severe or refractory conditions.

These qualities have won such wide recognition in standard texts on pharmacology and therapeutics that to prescribe Pro-Banthīne (propantheline bromide) is truly to prescribe "by the book."

The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime.

Side Effects And Cautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur with Pro-Banthīne (propantheline bromide). It is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthīne (propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

G. D. SEARLE & CO.
CHICAGO, ILLINOIS 60680
Research in the Service of Medicine

New U. of L. Microbiology Head To Assume Post July 1

Charles W. Fishel, Ph.D., currently assistant professor of microbiology at the University of Colorado Medical School, will take over July 1 as head of the department of microbiology at the University of Louisville School of Medicine.



Doctor Fishel

In announcing the appointment, Medical School Dean Donn L. Smith, M.D., said that Doctor Fishel will assume duties of James A. Kennedy, Ph.D., who has held the post since 1943. Doctor Kennedy will remain on the U. of L. faculty as a professor of microbiology.

Doctor Fishel, who took his bachelor and master's degrees from Montana State University, received his Ph.D. from the University of Chicago in 1955. He has done additional postgraduate work at the University of Chicago and Stanford University. Doctor Fishel was a research associate with the National Institute of Health, Bethesda, Md., from 1956-57. He has been at the University of Colorado since that time.

12 in Ky. Named Fellows of ACOG

Twelve Kentucky physicians, four of whom are with the Armed Forces here, will be inducted as Fellows of the American College of Obstetricians and Gynecologists at the May 17-22 clinical meeting of the ACOG at Bal Harbour, Fla.

New Fellows from Kentucky are: Joseph Liebman, M.D., Frankfort; James R. Barnes, M.D., James Childers, M.D., Martha J. Gilliland, M.D., Clinton Ray Potts, M.D., all of Louisville; Anthony R. Giglia, M.D., Newport; Jack C. Blackstone, M.D., Owensboro; and Alfred A. Jacobs, M.D., South Fort Mitchell. From Fort Campbell are Allan G. Bennett, Capt., MC, USAR, and Robert L. Mueller, Major, MC, USA. Others are Lloyd A. Kammeraad, Major, MC, USA, and John T. Leonard, Major, MC, USA, Fort Knox.

27 New Members Recorded On KSMA Roster

As of April 20, the records of the Kentucky State Medical Association show the addition of 27 physicians as new members.

Included in the list are: H. R. Booth, M.D., and F. G. Poore, M.D., both of Florence; J. D. Amis, M.D., Hopkinsville; Edwin H. Hanekamp, M.D., Owensboro; Plutarco A. Santana, M.D., and Loyal K. Wilson, M.D., both of Harlan; and Eli Khouri, M.D., Paducah.

Also listed are: John T. Teegan, M.D., Maysville; David L. Lawrence, M.D., Jamestown; Max E. Wheeler, M.D., Ashland; Keene Hill, Jr., M.D., Horse Cave; David F. Archer, M.D., and William Joule, M.D., both of Louisville; and three Madisonville physicians, A. T. Hall, M.D., E. E. Kawas, M.D., and John R. Love, M.D.

Daniel H. Stamper, Jr., M.D., Pikeville; George S. Beard, M.D., Hartford; James E. Gamble, M.D., Providence; and Robert B. Matheny, M.D., Sebree, are also named.

New KSMA members from Lexington are: John H. Burke, M.D., M. A. Carnes, M.D., James M. Chase, M.D., John L. Duhring, M.D., Vernon F. Hart, M.D., Joseph Hamburg, M.D., and L. O. Torkelson, M.D.

Dr. Rash Marks 67 Years of Medical Practice

Otway Watkins Rash, M.D., Owensboro surgeon, marked the 67th anniversary of his medical career on April 6.



Doctor Rash

To celebrate the occasion a group of friends presented him with a sterling silver cup. Presentation was made by his brother-in-law, Howell J. Davis, M.D., Owensboro, who is KSMA trustee for the second district.

Doctor Rash graduated from Bellevue Hospital Medical College in 1897 and received his license to practice in Kentucky that same year. Except for service in the Spanish-American War, he has practiced in Kentucky throughout his career. He is a past president of the Daviess County Medical Society, a fellow of the American College of Surgeons, and one of the organizers of the Kentucky Society for Crippled Children.

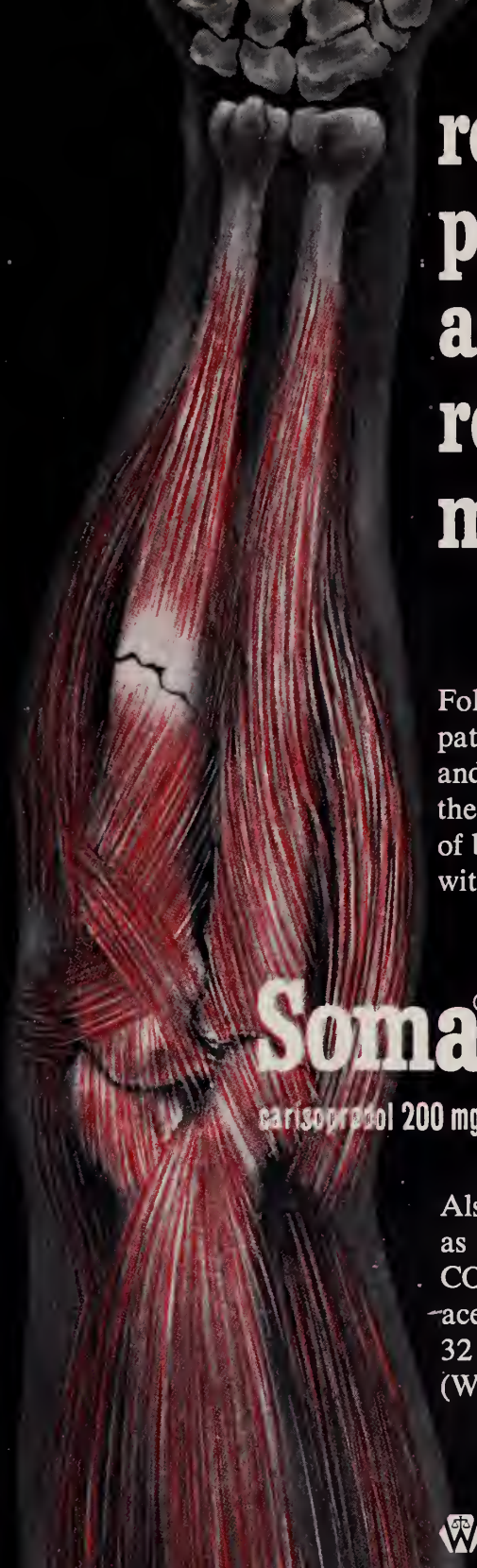
AMA Answers Queries on Belgium

The American Medical Association when requested by the press for comment on the Belgian situation has responded that it "has no official policy on the questions of physicians striking since it has never been an issue in this country with our system of medical freedom for both patients and physicians."

The AMA further states that, "The Belgian situation, however, is a dramatic example of what a beleaguered profession may be driven to do when it feels that its very freedom is being destroyed. It is not for us to judge the wisdom of their reaction but to appreciate that physicians—like all others—can be incited to revolt by politicians who seek to take over the practice of medicine."

Dr. Glazer Gets AAGP Award

Norman Glazer, M.D., Louisville, received a placque and a check for $1,000 from the American Academy of General Practice, for the outstanding article published in *GP* during 1963. The award for the article, on medicine in sports, was made April 15 at Atlantic City during the AAGP's annual meeting.



relieves pain and relaxes muscle

TRAUMA!

Following traumatic injury, patient comfort can be increased and recovery time shortened by the simultaneous treatment of both pain and muscle spasm with 'Soma' Compound.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Also available with ¼ gr. codeine as SOMA® COMPOUND WITH CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit forming).

WALLACE LABORATORIES/*Cranbury, N.J.*

Side effects: Although there has been no evidence of tolerance, withdrawal symptoms or excessive self-medication, 'Soma' Compound and 'Soma' Compound with Codeine, like other central nervous system depressants, should be used with caution in addiction-prone individuals. While codeine addiction is relatively rare and easily broken, the same precautions must be observed as for any other opium alkaloid. Nausea, vomiting, constipation and miosis are possible codeine side effects. Should symptoms of hypersensitivity occur, discontinue medication.

Contraindications: None reported.

Complete product information available in the product package, and to physicians upon request.

Dosage: Usual dosage is 1 or 2 tablets 4 times daily.

Supplied: 'Soma' Compound is available in orange, scored tablets; bottles of 50. 'Soma' Compound with Codeine (narcotic order form required) is available in white, lozenge-shaped tablets; bottles of 50.

CSQ-1045

Louisville C. of C. Backs Plan To Form Area Hospital Council

The Louisville Chamber of Commerce announced in April that its officers and staff will take the lead in the formation of a Louisville Metropolitan Area Hospital Planning Council.

Kenneth P. Vinsel, executive vice-president of the 2,700-member business organization, said the move "is one of the most important steps in long-range community planning taken in several years. Its implications are far-reaching, and its implementation could go far to check the rising cost of hospital care and other health care."

At the recommendation of the Economic Advisory Committee, the Chamber Board of Directors approved taking the lead in formation of the Council. Henning Hilliard, as chairman of that committee, headed the study on whether such a planning group is needed.

In recommending to the Board that the Chamber take this step, Mr. Hilliard said a hospital planning council would not necessarily achieve lower hospital costs, but could help to halt their continuing increase and would enable the Louisville community to "get the most for the health-care dollar."

"In the Louisville Metropolitan area," he said, "we have not yet been faced with the acute problem of efficient utilization of the health dollar to the same extent it has been present in some other areas of the nation. However, it is obvious to those directly involved that only through effective planning and coordination can we avoid the construction of unneeded hospital facilities and expensive duplication of equipment, and encourage the construction of needed facilities."

Dr. Murray Receives Award As Outstanding Educator

Marvin Murray, M.D., assistant professor of pathology and associate in surgery at the University of Louisville School of Medicine, was one of 15 outstanding medical educators to share in $250,000 in awards given by the Lederle Laboratories at a dinner April 13 in Chicago.

Since the inception of the program in 1954, Lederle, a division of the American Cyanamid Company, has made annual cash awards to medical school faculty members for their dedication to medical teaching. The purpose of the awards is to help maintain the high caliber of medical education in the United States and Canada.

Doctor Murray, who has been at the University of Louisville since 1959, was awarded his M.D. by Wayne State University in 1955. He also holds a Ph.D. from Michigan State University.

Henderson Dinner is May 21

Beverly Mead, M.D., of the University of Kentucky School of Medicine will be the featured speaker at the Henderson M.D.—Lawyer Dinner which is scheduled for May 21.



Discussing final plans for the closed retreat for physicians, dentists, and pharmacists held during Holy Week at Marydale Retreat House, near Erlanger, are Paul H. Klingenberg, M.D., Covington, left, Earl E. Schuh, D.D.S., Park Hills, Jack Anneken, Covington pharmacist, and Roy J. Moser, Jr., M.D., South Fort Mitchell, who, with Doctor Klingenberg, made the arrangements for the annual event.

Northern Ky. M.D.s Join In Annual Holy Week Retreat

As has been their custom for the past five years, Northern Kentucky physicians joined with pharmacists and dentists from that area in a three-day religious retreat traditionally held the week before Easter at Marydale Retreat House near Erlanger.

From March 24-26 of this year, 32 members of those three professions and allied groups gathered at Marydale to enjoy a period of respite from the pressures of the outside world, to meditate in an atmosphere of complete silence, and to take part in prayers and religious observances.

The annual retreat, organized more than five years ago by Covington-area physicians, is not limited denominationally or to the Northern Kentucky region. Paul H. Klingenberg, M.D., Covington, secretary of the Campbell-Kenton County Medical Society, was in charge of this year's retreat. He was assisted by Roy J. Moser, Jr., M.D., South Fort Mitchell. The event is entirely self-sustained, supported by donations of participants.

GYNE-CYTOLOGY LABORATORY, INC.

M. Wm. Rubenstein, M.D.

(PAPANICOLAOU METHOD)

RAPID SERVICE —
Mailing Kits On Request

Suite 422 — 636 Church Street
EVANSTON, ILLINOIS, 60201

News Items

Robert C. Long, M.D., Louisville, participated in an hour-long debate with Liz Bamberger, first assistant director of the Social Security Department of the AFL-CIO in Washington, D. C., Sunday, April 5. The debate was sponsored by the Columbus Town Hall, Columbus, Ohio, and broadcast over a local television station.

Robert B. Chambliss, a 1963 graduate of the University of Tennessee School of Medicine, has started general practice in Burkesville. He completed his internship at Louisville General Hospital in April of this year.

C. Melvin Bernhard, M.D., Louisville surgeon, received a bronze medal on April 16 from the American Cancer Society's Louisville division "In recognition of his outstanding contribution to the control of cancer in 1963." Doctor Bernhard has been active locally and nationally in cancer work.

J. Kenneth Eakins, M.D., Louisville, is practicing part-time with the Handicapped Children Commission while attending Southern Baptist Seminary in preparation for entering the ministry. Doctor Eakins, a pediatrician, was graduated from the University of Illinois School of Medicine in 1956.

Claire B. Sledge, M.D., has entered the practice of pathology in Paducah, in association with **Donal D. O'Sullivan, M.D.** Doctor Sledge, a 1948 graduate of the University of Oklahoma College of Medicine, interned at Wesley Hospital in Oklahoma City, and was a resident at St. Francis Hospital and at the Mayo Clinic, Rochester, Minn.

Daniel W. Wingard, M.D., has joined the staff of the Medical Center of the University of Kentucky, where he will teach and practice anesthesiology. A 1959 graduate of Western Reserve School of Medicine in Cleveland, Doctor Wingard interned at Akron General Hospital, and completed his residency at the University Hospital at Cleveland in 1962. Before coming to U.K., he was an instructor in anesthesiology at Western Reserve.

C. Gordon Gussler, M.D., Ashland ophthalmologist, was honored February 25 by the Ashland and Russell Lions clubs, for his part in restoring the sight of a young Boyd County girl sponsored by the Russell Lions Club. Doctor Gussler received a desk statuette of a lion for his voluntary efforts in aiding the club's eyesight conservation program.

Ellis A. Fuller, M.D., Louisville internist and assistant clinical professor of medicine at the University of Louisville, was recently given a Browers Traveling Scholar award by the American College of Physicians. Doctor Fuller, who is director of the American Red Cross Regional Blood Center in Louisville, will study for a month at Washington University and Barnes Hospital in St. Louis.

Paul F. Rizk, M.D., Grayson, has announced that he has joined the staff of the Riverview Hospital in Louisa. Doctor Rizk was a member of the staff of the J. Q. Stovall Hospital in Grayson until its closing in January of this year.

1st KHA Community Service Award Given to KSMA Exec. Sec.

KSMA Executive Secretary J. P. Sanford, Louisville, received the first Community Service Award of the Kentucky Hospital Association at the KHA annual meeting in Louisville on April 1.

The award was given to him as "an expression of appreciation for noteworthy service" and as a "special recognition for the time and effort spent in endeavors which have meaning to the health and well being of so many Kentucky citizens".

This is the first year the award has been presented. It will be given annually at KHA annual Meetings. Sanford joined the KSMA staff in 1950 and has been executive secretary since 1951.



Kentucky's 1963 Dairy Princess, lovely Miss Jane Harrison, Farmington, served milk to, from the left, William Padon, Louisville, Edmond Yantes, M.D., Wilmington, Ohio, and Donald Graves, M.D., Frenchburg, participants in the Kentucky Rural Health Conference held last October 21 at Jenny Wiley State Park, Prestonsburg. Doctor Yantes is a member of the AMA Rural Health Council and Doctor Graves is chairman of the KSMA Rural Health Committee. This year's Kentucky Dairy Princess, Miss Phyllis Maze of Salt Lick, will make public appearances across the state during the month of June in promotion of National Dairy Month.

June is Nat'l. Dairy Month

KSMA is cooperating with the American Dairy Association of Kentucky in promoting June as National Dairy Month. During the month, posters and television and newspaper ads will highlight the health aspects of dairy foods.

Commenting on National Dairy Month, Donald L. Graves, M.D., Frenchburg, chairman of the KSMA Rural Health Committee, said, "The KSMA appreciates the generosity of the American Dairy Association of Kentucky in donating free milk to the annual Rural Health Conference". Recently the ADA of Kentucky sponsored radio broadcasts of the Kentucky State High School Basketball Tournament.

Hospital Week Starts May 10

Progress of hospitals in providing the best and most up-to-date medical care will be emphasized during National Hospital Week, May 10-16. National Hospital Week, held annually during the week of Florence Nightingale's birthday (May 12), offers a timely occasion for a look at hospitals and the role they play in providing health care.


for the
patient with
'pain &
spasm'

pain is almost invariably a presenting symptom in cases of skeletal muscle spasm

In some instances, the pain subsides on relaxation of the muscles in spasm. In others, relaxant therapy alone fails to give adequate relief, and supplementary analgesia (and possibly sedation) are indispensable, as in cases of:

provocative pain, when muscle spasm is triggered by some painful underlying musculoskeletal defect.

residual pain, when relaxation of severe spasticity leaves a degree of myalgia that tends to reinvoke spasm.

severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

emotionally aggravated pain, when anxiety or agitation creates tension that thwarts the efficacy of both relaxant and analgesic medication.

In such cases, ROBAXISAL and ROBAXISAL-PH have proven highly effective in assuring decisive and comprehensive relief. The ROBAXISAL formula—of ROBAXIN (methocarbamol), the potent muscle relaxant, together with aspirin, the time-tested and proved analgesic—produces higher plasma salicylate levels than equivalent doses of aspirin alone, and serves effectively to control both spasm and pain. ROBAXISAL-PH's combination of ROBAXIN (methocarbamol) with the analgesic-sedative ingredients of the PHENAPHEN formula—including phenobarbital—helps additionally to ease apprehension.

ROBAXISAL®

Robins

Each pink-and-white laminated Tablet contains:
ROBAXIN (methocarbamol, Robins) .....400 mg. Aspirin (5 gr.).....325 mg.
U.S. Pat. No. 2770649

ROBAXISAL®-PH

Each green-and-white laminated Tablet contains:
ROBAXIN .....400 mg. (methocarbamol, Robins)
Phenacetin (1½ gr.)....97 mg.
Aspirin (1¼ gr.).....81 mg.
Hyoscyamine sulfate 0.016 mg.
Phenobarbital (⅛ gr.)....8.1 mg.
(Warning: May be habit forming)



"PAIN & SPASM"
–a two-headed dragon!

ROBAXISAL and ROBAXISAL-PH are indicated in strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

Side effects such as lightheadedness, slight drowsiness, dizziness and nausea may occur rarely in patients with intolerance to drugs, but they usually disappear on reduction of dosage.

Contraindicated for patients hypersensitive to any component of the formulations. There are no specific contraindications to methocarbamol, and untoward reactions are not to be expected.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

MAY

12	KSMA 12th & 15th Trustee Districts Meeting, Somerset, Ky.
13	KSMA 6th Trustee District Meeting, Russellville, Ky.
13-14	Kentucky Pediatric Society, Medical Arts Building, Louisville, Ky.
14	Kentucky Mental Health Congress, Kentucky Hotel, Louisville, Ky.
14	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
14	KSMA 4th Trustee District Meeting, Bardstown, Ky.
15*	Electrocardiography Course, University of Kentucky, Lexington, Ky.
18-22	Refresher Course in Physiology for Practicing Physicians, University of Kentucky, Lexington, Ky.
21	KSMA 7th Trustee District Meeting, Science Hill Inn, Shelbyville, Ky.
21	University Surgery Day, University of Kentucky, Lexington, Ky.
22*	Electrocardiography Course, University of Kentucky, Lexington, Ky.
26	KSMA 2nd Trustee District Meeting, Owensboro, Ky.
27	KSMA 1st Trustee District Meeting, Paduach, Ky.
29	Monthly Continuing Pediatric Seminar, University of Kentucky, Lexington, Ky.
29*	Electrocardiography Course, University of Kentucky, Lexington, Ky.

JUNE

3	KSMA 9th Trustee District Meeting, Paris, Ky.
4	KSMA 8th Trustee District Meeting, Covington, Ky.
4	KAGP Seminar, Beaumont Inn, Harrodsburg, Ky.
4-6	Newer Methods in Diagnosis, University of Kentucky, Lexington, Ky.
11	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
18	KAGP Seminar, Henderson, Ky.

JULY

22-23	Cumberland Valley Seminar, KAGP, S.E. Kentucky Baptist Hospital, Corbin, Ky.
25-26	Community Disaster Planning, AMA Committee on Disaster Medical Care, Stouffer's Inn, Louisville, Ky.
30	West Kentucky Seminar, KAGP, Irvin Cobb Hotel, Paducah, Ky.

SURROUNDING STATES

MAY

11-12	Diseases of the Newborn Infant, University of Cincinnati & Children's Hospital, Cincinnati, Ohio.
17-22	American College of Obstetricians & Gynecologists, Bal Harbour, Fla.
20	Management of Diabetes, Indiana University, Indianapolis, Ind.
20-21	Clinical Advances in Medicine & Pediatrics, University of Missouri, Columbia, Mo.
21	Diagnosis & Treatment of Collagen Disease, Indiana University, Indianapolis, Ind.
24-27	National Tuberculosis Association, Statler-Hilton, New York, N.Y.
24-27	American Thoracic Society, Statler-Hilton, New York, N.Y.
28-30	American Ophthalmological Society, Hot Springs, Va.

JUNE

14-19	7th Inter-American Congress of Cardiology, Montreal, Canada.
17-21	Refresher Course in Diagnostic Radiology, University of Cincinnati, Cincinnati, Ohio.
18-19	American Pediatric Society, Seattle, Wash.
18-22	American College of Chest Physicians, San Francisco, Calif.
21-25	American Medical Association, San Francisco, Calif.

* Electrocardiography course being held at U. of K. on consecutive Friday evenings will end May 29.



In Fractures: B and C vitamins are therapy

Stress formula vitamins are a key factor in bone and tissue regeneration. To meet the increased metabolic demands, STRESSCAPS offers therapeutic amounts of B and C vitamins as an aid to smoother convalescence and earlier rehabilitation. In fractures, as in many other conditions of physiologic stress, STRESSCAPS vitamins are therapy.

Each capsule contains:

Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

7283-4

Medical School News

State Bonds May Aid U. of L. To Build Education Unit

The University of Louisville will receive $3,000,000 from the State's proposed multimillion dollar bond issue toward construction of a new medical-dental educational building.

The Kentucky General Assembly passed a bill allowing the bond issue to be placed on the ballot of the November, 1965 general election, for voter approval. The state funds would be approximately half of what the university needs to qualify for $6 to $12 million in Federal matching funds.

U. of L. in February received a check for $50,000 from the State to begin drawing plans for the new education facility, to cost an estimated $12 to $18 million. The planned construction will replace the outmoded buildings now housing the medical and dental schools.

Lecture Series to Honor Dr. Johnson

A memorial lectureship series named in honor of the late W. O. Johnson, M.D., head of the department of obstetrics and gynecology at U. of L. from 1947 to 1957, has been established at U. of L. by the Louisville Obstetrical and Gynecological Society. First lecturer of the series, on March 28, was Axel Arneson, M.D., professor of ob-gyn at Washington University Medical School at St. Louis, a personal friend of Doctor Johnson. The lecture is to be an annual event.

New Research Grants total $371,200

University of Louisville School of Medicine researchers have recently received a total of $371,200 for studies in various areas of medicine.

A project carried on by the department of pediatrics at U. of L. for the study of twins in relation to human development, has received a grant of $300,000 from the National Institutes of Health, according to Frank Falkner, M.D., chairman of the department, in a March 27 announcement. Steven G. Vandenberg, Ph.D., associate professor of child development research, will continue to direct the project.

K. C. Huang, M.D., professor of pharmacology, received a $39,700, two-year grant from the National Science Foundation for the study of amino-acids and how they enter the body.

$17,000 was recently made available to Charles H. Jarboe, Ph.D. assistant professor of Pharmacology at U. of L., by the National Science Foundation to aid in the study of hydrogen bonding.

Marvin Murray, M.D., assistant professor of pathology, received a three-year, $10,500 grant April 13 from the Lederle Laboratories division of American Cyanamid Company for a study of blood-clotting.

Additional awards of $3,500 from Lloyd Brothers, Inc., Cincinnati, for the establishment of a kidney-research fund, and $500 from Duke Laboratory Foundation for dermatological studies, were given to the department of medicine.

U.K. to Give Honorary Degrees At May Commencement

Erwin J. Straus, M.D., and J. Stephen Watkins, both of Lexington are among the recipients of honorary doctor of laws degrees to be awarded by the University of Kentucky at its May 18 Commencement exercises.

Doctor Straus, director of research and education at the Veteran's Administration Hospital in Lexington, is on the faculty of the University of Kentucky College of Medicine. In recommending Doctor Straus, John Oswald, Ph.D., University president, cited him for fostering cooperative research programs between the Hospital and U.K.

Mr. Watkins, the first president of the Kentucky Medical Foundation, was recognized by Doctor Oswald as being "more than any other single individual" responsible for action that led to the establishment of the U.K. Medical Center.

Professor Gets Study Grant

Donald L. Hochstrasser, M.D., assistant professor of Community Medicine at the University of Kentucky, has received a $10,804 grant from the National Tuberculosis Association to continue his studies on the health behavior of nonhospitalized tuberculosis patients. This is the second year the NTA has supported Doctor Hochstrasser's project.

The Modern Physician



must spend many hours keeping himself informed so that he may better serve his patients and his profession. Today, a doctor refers cases requiring special techniques to those trained in handling them.

Just so, select your jeweler who must have training, experience and an established reputation for honesty and dependability. KENDRICK is such a jeweler, being a REGISTERED JEWELER of the AMERICAN GEM SOCIETY. Call on us at any time for expert advice and assistance in selecting quality gems. This service costs no more.

Kendrick
Jewelers since 1832
MEMBER AMERICAN GEM SOCIETY
619 SO. FOURTH ST. 584-5232

KSMA Council and Committee Reports

Mental Health Committee

Frank M. Gaines, M.D., Louisville, Chairman

Louisville **Thursday, March 26, 1964**

The KSMA Mental Health Committee, meeting for its second time this Associational year, concentrated its efforts on making final arrangements for the First Kentucky Congress on Mental Health which will be held at the Kentucky Hotel, Louisville, May 14.

The budget and promotion plans for the Congress were approved by the committee members. The chairman announced that the Kentucky Association for Mental Health would be an additional co-sponsor for the Congress. A registration fee of $2 was set for all Congress participants.

Public Health Committee

M. A. Shepherd, M.D., Somerset, Chairman

Louisville **March 19, 1964**

The Public Health Committee announced at a recent meeting that May 3-9 would be Immunization Week in Kentucky. Promotion plans for the program were approved and the cooperation of all KSMA members was requested.

Members of the committee again discussed the necessity of reporting cases of venereal diseases if effective control of the disease is to be established.

The subject of "Tobacco & Health" was discussed, and it was reported that the AMA was initiating a research project on this subject. The committee members indicated their desire to see a symposium on "Tobacco & Health" at some future KSMA Annual Meeting after the AMA Research Project has been completed.

The meeting closed with an expression of appreciation to the KSMA Diabetes Committee for their outstanding Diabetes Detection and Education Program.

Mexico Site of Chest Congress

The eighth International Congress on Diseases of the Chest is scheduled for October 11-15 in Mexico City, Mexico. More than 3000 delegates are expected to attend the Congress which is sponsored by the American College of Chest Physicians.

Wholesale Drugs

and

Physicians Supplies

JOHN T. VIE CO., INC.

WH 4-7784 New Albany, Ind.

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

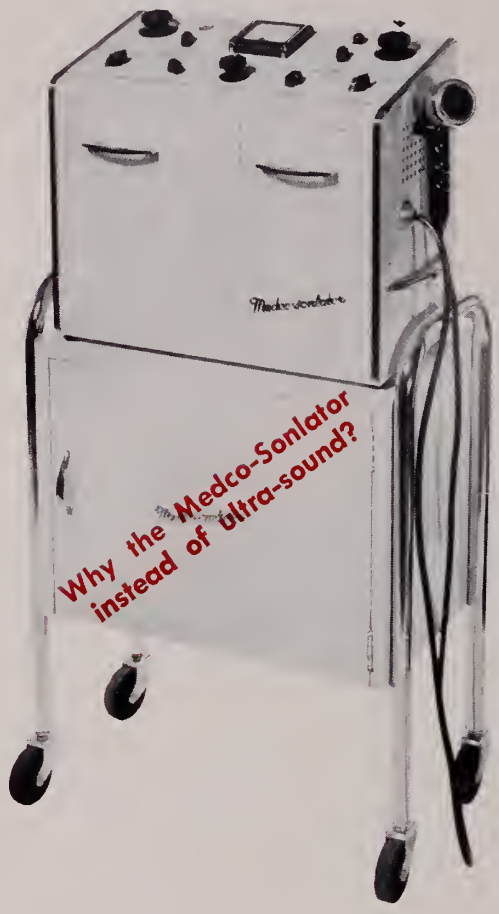
CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey

Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

MEDCO ELECTRONICS CO., INC.

MR. STAN CURELLA, REPRESENTATIVE

454-6333



MEDCO ELECTRONICS CO., INC.
Mr. Stan Curella
1638 Sutherland Drive
Louisville 5, Ky.

☐ I would like an office demonstration of your Medco-Sonlator

☐ Please send me your illustrated literature on the Medco-Sonlator

Name _____

Address _____

City _____ State _____

Regional PH Office Opened in Somerset March 2

Kentucky's first regional public health office opened March 2 in Somerset, Russell E. Teague, M.D., commissioner of health announced recently.

It is hoped that eventually there will be six of these Regional offices covering 20 counties each. The offices will actually be branch offices of the State Department of Health and will be staffed by field personnel.

The Somerset office will "support and strengthen" health programs in 20 south central counties, according to Doctor Teague. Director of the regional office is M. A. Shepherd, M.D., former health officer for Pulaski, Rockcastle, and McCreary Counties. Doctor Shepherd, a graduate of the University of Louisville School of Medicine in 1953, also holds a master's degree in public health administration from the University of North Carolina.

Primary function of the regional offices will be to help county health departments identify public health problems and to help meet their needs through better use of community resources.

March 30 Doctor's Day Observed in State

Doctor's Day, observed annually on March 30 in honor of all physicians, was celebrated in various ways this year across the state of Kentucky.

A project of the Woman's Auxiliary to the Southern Medical Association, Doctor's Day is observed on March 30 in remembrance of that date in 1842 when Crawford Williamson Long, M.D., of Jefferson, Ga., was the first to use ether as an anesthetic.

The Fayette County Medical Society Auxiliary presented a cash gift to the Ephraim McDowell shrine in Danville in honor of the medical pioneer who performed the first successful operation for the removal of an ovarian tumor.

Fulton county physicians were entertained by their wives at a dinner on March 31 at the Park Terrace. The Pulaski County Auxiliary paid office or home calls on each physician in the county to present red carnation boutonnieres as a mark of appreciation.

The Auxiliary to the Mason County Medical Society also presented carnations to each physician, and Doctor's Day was made an official observance in Laurel County by official proclamation.

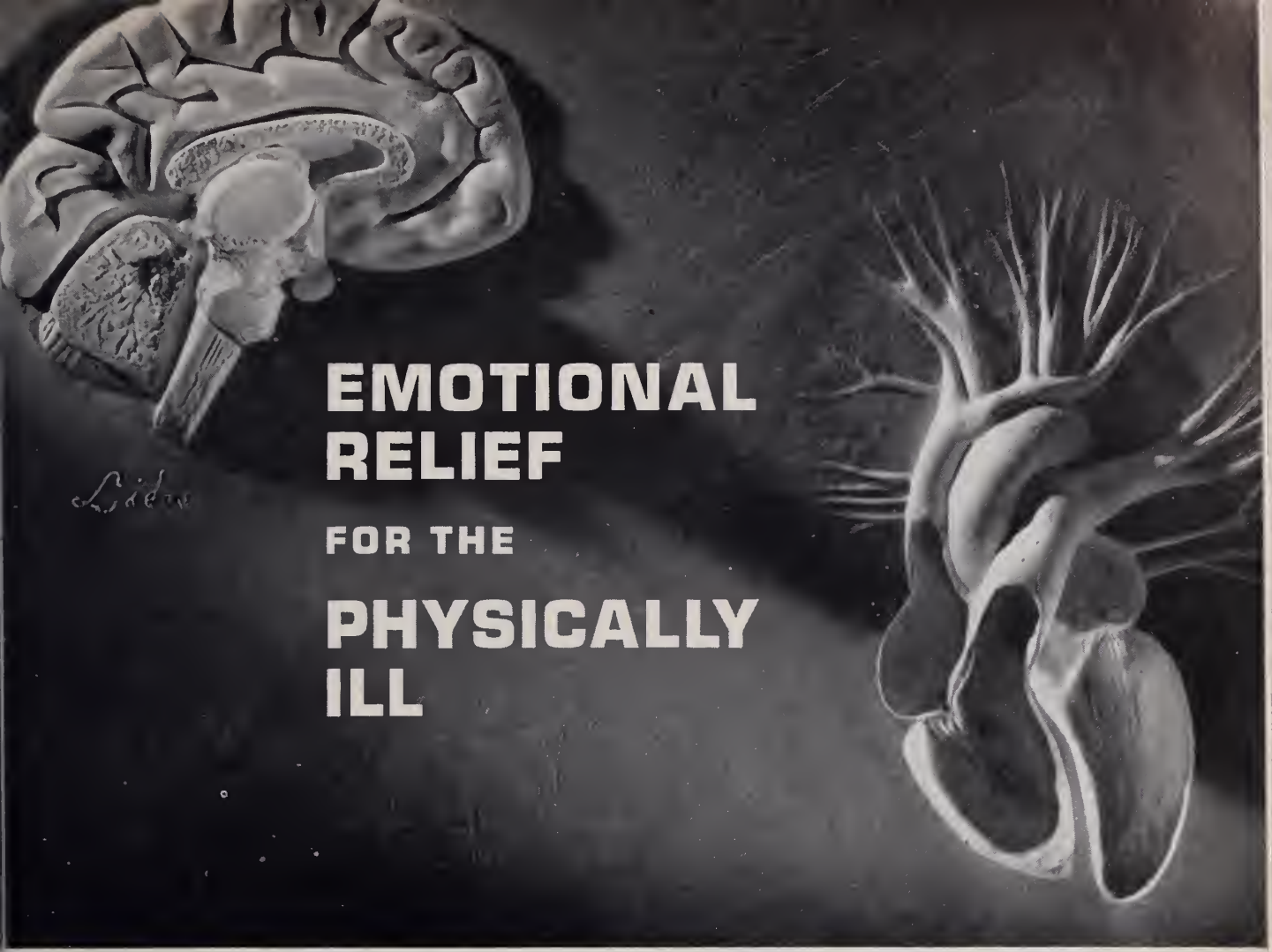
At Owensboro, the Auxiliary to the Daviess County Medical Society, in sponsoring the local Doctor's Day celebration, honored John Roberts, M.D., a county pioneer in medicine, who practiced in that area for over 40 years, beginning around 1808.

Newspapers in many areas of the state paid editorial tribute to the physicians of their communities.

Ophthalmology Papers Due May 15

The Section of Ophthalmology of the Southern Medical Association has announced that papers to be considered for presentation at the Memphis meeting, November 16-19, will be accepted only up to May 15.

The meeting this year is under the chairmanship of Albert C. Esposito, M.D., Huntington, W. Va.



RELIEVES ANXIETY, APPREHENSION AND TENSION...



All day long
. . . keeps the patient calm, and the mind clear.



All night too
. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400
(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CME-760

WALLACE LABORATORIES *Cranbury, N. J.*

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

(Research and Teaching Exhibits)

1964 Annual Meeting — Kentucky State Medical Association

Convention Center — **Louisville, Kentucky** — **Sept. 29, 30; Oct. 1**

Fill Out and Mail to:

BENJAMIN B. JACKSON, M.D., Chairman

Committee on Scientific Exhibits

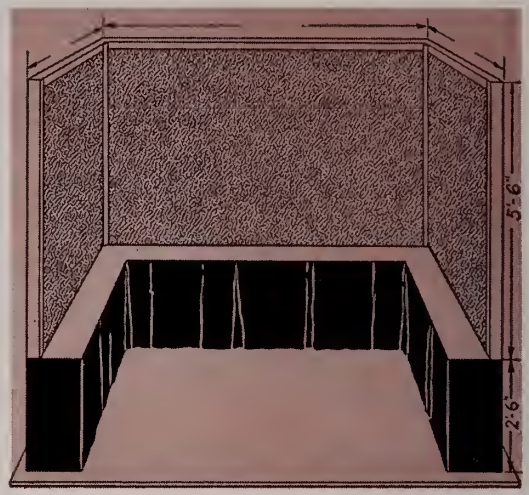
Kentucky State Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1964

Dimensions and structure of KSMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....

   .....

   Institution (if desired): .....

   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

   Charts and Posters.... Photographs.... Drawings.... X-rays....

   Specimens.... Moulages.... Other Material..... (Describe)
6. Booth Requirements:

   Amount of wall space needed? .....

   Back wall .....Side walls (All side walls are 4') .....

   Square feet needed? .....Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

Signature of Applicant

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KSMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.

In Memoriam

CHARLES E. GAUPIN, M.D.
Louisville, Ky.
1891-1964

Charles E. Gaupin, M.D., Louisville obstetrician who retired last July, died March 21 at the age of 73. Doctor Gaupin, a 1912 graduate of the Medical Department of the University of Louisville, was a member of the clinical faculty of the present school of medicine from 1916 to 1930.

EMMETT HAYES MILLER, M.D.
Vine Grove, Ky.
1879-1964

Emmett H. Miller, M.D., 84, Vine Grove, died March 11. Doctor Miller, who had practiced general medicine in Vine Grove, Flaherty, and for 20 years in Harlan, was a 1906 graduate of the Medical Department of the University of Louisville. He had served in the Army Medical Corps in both world wars. He had been retired for several years.

FRANK LESLIE PEDDICORD, M.D.
Louisville, Ky.
1871-1964

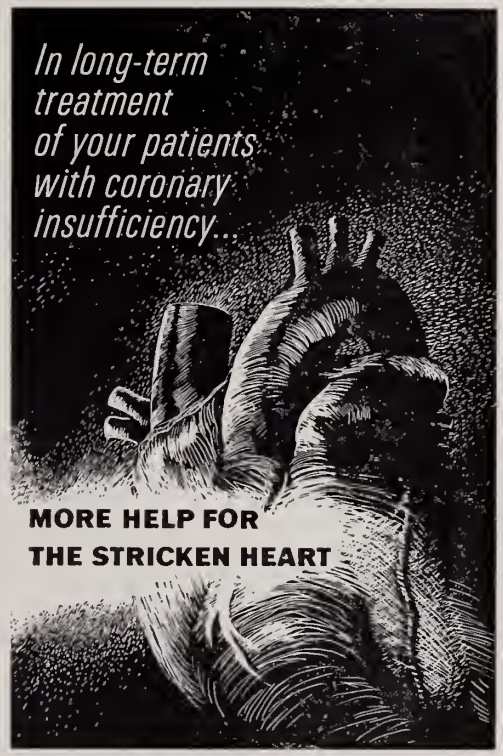
Frank L. Peddicord, M.D., who served as superintendent of Central State Hospital from 1914 to 1918, died at a nursing home in Louisville on Thursday, April 9. A native of Bracken County, he graduated from the Kentucky Medical School in 1906 before it became a part of U. of L. From 1937 to 1957, Doctor Peddicord resumed his service to Central State as a staff doctor and, at various times, as acting superintendent. A member of the American Psychiatric Association, he was retired from active practice at the time of his death.

RAYMOND MYERS EVANS, M.D.
Louisville, Ky.
1889 - 1964

Raymond M. Evans, M.D., 74, retired Louisville surgeon who had practiced in that city for 36 years, died April 15 at his home. A 1914 graduate of the Medical Department of Vanderbilt University, Doctor Evans had practiced in Nashville, Cleveland, and at the Mayo Clinic in Rochester, Minn., before coming to Louisville in 1921. An emeritus member of the Kentucky State Medical Association, he was a veteran of World War I.

AMA Subscription Information

County medical societies, state medical societies, approved medical schools and dues-exempt members of the AMA are reminded that they are eligible to purchase subscriptions for American Medical Association at the special 50% rate, according to a recent memorandum from the AMA's circulation and records department.



■ PETN (pentaerythritol tetranitrate) to increase oxygen supply

■ plus meprobamate to decrease anxiety and tension

Unlike phenobarbital, meprobamate is *not* cumulative and does *not* cause depression.

Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. **Precautions:** Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. **Contraindications:** Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* **Dosage:** 1 to 2 tablets, *before meals* and at bedtime. Individualization required. **Supplied:** Bottles of 50 tablets.

CML-1055

MILTRATE®
meprobamate 200 mg. + pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective **GERIATRIC** antiarthritic with

REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate-SF

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium para-aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe
PABALATE-SODIUM FREE

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

279-4

County Society Reports

Boone

James M. Huey, M.D., Walton, took office January 1 as president of the Boone County Medical Society, it was recently announced. Also taking office at that time were: Philip B. Schworer, M.D., Florence, vice-president; William M. Waller, M.D., Walton, treasurer; and Harry R. Daugherty, M.D., Florence, secretary. LeRoy C. Hess, M.D., Florence, will be the society's 1964 delegate to KSMA, with Doctor Waller as alternate.

Bourbon

Byron N. Pittenger, M.D., Paris, took office March 1 as 1964 president of the Bourbon County Medical Society, it was recently announced. Other officers are James L. Ferrell, M.D., Paris, vice-president, and James E. Johnson, Jr., M.D., Millersburg, secretary-treasurer. Richard J. Wever, M.D., Paris, will serve as delegate to the KSMA House of Delegates, and Erwin Asriel, M.D., Paris, as alternate delegate.

Franklin

Harry J. Cowherd, M.D., took office January 1 as president of the Franklin County Medical Society. Other 1964 executives are: Dallas Hagg, M.D., vice-president, and Carl E. Shroat, M.D., secretary-treasurer. John Stewart, M.D., will be the delegate to the Kentucky State Medical Association. Donald Howard, M.D., is alternate delegate. All are from Frankfort.

Graves

William B. Simpson, M.D., Mayfield, will serve as president of the Graves County Medical Society for the coming year, according to a recent report. Also elected were Thomas B. Stone, M.D., Mayfield, vice-president, and J. R. Van Arsdall, M.D., Mayfield, secretary-treasurer. Robert A. Orr, M.D., and C. F. Burnett, M.D., both of Mayfield, will serve as delegate to KSMA and alternate delegate, respectively.

Hardin

Recently elected officers of the Hardin County Medical Society are Thomas J. Ferriell, Jr., Elizabethbethtown, president; Curtis Lee Songster, M.D., Vine Grove, vice president; and Ollie B. Emerine, M.D., Elizabethtown, treasurer and secretary. R. T. Routt, M.D., Sonora, was elected KSMA delegate.

Giles L. Stephens, M.D., Louisville, was the featured speaker at a meeting of the Hardin County Medical Society in Elizabethtown on April 2. Subject of his talk was "Recent Advances in Vein Thrombosis and Its Complications".

Hickman

Vester A. Jackson, M.D., Clinton, will serve the Hickman County Medical Society as its president for 1964 and 1965, it was recently announced. Secretary-treasurer for the Hickman County Society is H. E. Titsworth, M.D., also of Clinton. Neither a delegate nor alternate delegate to the Kentucky State Medical Association had been reported at the time of this writing.

Jessamine

Marvin C. Pentz, M.D., Nicholasville, was elected president of the Jessamine County Medical Society at a recent meeting. J. Sankey Williams, M.D., Nicholasville, was elected vice president and secretary and treasurer. Delegates to KSMA are Doctor Williams and Wallace E. Combs, M.D., Nicholasville.

Lawrence

William J. McNabb, M.D., will head the Lawrence County Medical Society in 1964, it was recently announced. Serving with Doctor McNabb will be A. W. Wright, M.D., as vice-president and delegate to the Kentucky State Medical Association, and G. P. Carter, M.D., secretary-treasurer. Doctor McNabb will serve as alternate delegate to KSMA. The officers are from Louisa.

Lyon

James E. Hamilton, M.D., is serving as president of the Lyon County Medical Society for 1964, it has been announced. M. H. Moseley, M.D., Eddyville, is secretary and treasurer. Doctor Hamilton, also of Eddyville, will be the County Society's delegate to the KSMA House of Delegates, and Doctor Moseley will serve as alternate.

Marshall

Currently serving as president of the Marshall County Medical Society is Carroll W. Traylor, M.D., Calvert City, according to a recent report. Also acting as officers for the Marshall Society are George C. McClain, M.D., Benton, vice-president; and Harold L. King, M.D., Benton, secretary-treasurer. Joseph R. Miller, M.D., Benton, will be delegate to the KSMA, and William J. Colburn, M.D., Calvert City, will be the alternate delegate.

Mason

Officers representing the Mason County Medical Society for 1964 will be Claude E. Cummins, Jr., M.D., president; and Robert M. Blake, M.D., secretary-treasurer, both of Maysville. The delegate and alternate delegate to the Kentucky State Medical Association have not yet been named.

Morgan

George R. Bellamy, M.D., has been named president for the coming year of the Morgan County Medical Society. Other society executives elected at the same time are: Morris L. Peyton, M.D., vice-president; H. B. Murray, M.D., president-elect; and Alec Spencer, M.D., secretary-treasurer. Doctor Peyton will serve as delegate to the Kentucky State Medical Association, and Doctor Murray as alternate. All the officers are from West Liberty.

Monroe

William R. Bushong, M.D., Tompkinsville, was recently installed as 1964 president of the Monroe County Medical Society. Serving with Doctor Bushong will be Wendell F. Hurt, M.D., Tompkinsville, vice-president, and Clovis A. Crabtree, M.D., Gamaliel, secretary-treasurer. The delegate to KSMA from the

Monroe County Society will be John C. Marsh, M.D., Gamaliel. Alternate delegate is T. L. Carter, M.D., Tompkinsville.

Muhlenberg

"Juvenile Abdominal Carcinoma" was the subject of a clinical report given by George H. Rodman, M.D., Greenville, at the April 6 meeting of the Muhlenberg County Medical Society.

Joseph Stokes, M.D., Greenville, KSMA legislative key man, presented a detailed review of the medical and health problems which had been considered by the recent session of the legislature. It was agreed that the KSMA Legislative Council had functioned most satisfactorily.

A letter from Bobbie R. Grogan, KSMA director of Field Services, was read and as a result the society voted to express its thanks to Senator Thomas Brizendine and Representative Fred Wallace for their understanding and cooperation.

Russell

Officers for the coming year were recently named by the Russell County Medical Society. James B. Tarter, M.D., will serve as president, Charles E. Peck, M.D., vice-president, and Joe T. Pettey, M.D., secretary-treasurer. All are from Russell Springs. Delegate to KSMA from Russell County will be Doctor Peck, with David L. Lawrence, M.D., Jamestown, serving as alternate.

Scott

F. W. Wilt, M.D., Georgetown, took office January1 for a two-year term as president of the Scott County Medical Society. J. C. Cantrill, M.D., Georgetown, is secretary-treasurer of the society. Doctor Cantrill will serve as the Scott County Society's delegate to KSMA, and Doctor Wilt as alternate.

Taylor

L. S. Hall, M.D., Campbellsville, has been chosen to head the Taylor County Medical Society for 1964. Serving with Doctor Hall will be M. M. Hall, M.D., vice president, who is also from Campbellsville and is the Society's president-elect. W. R. Mann, M.D., Campbellsville, is secretary-treasurer. Delegate to the Kentucky State Medical Association will be Forest Shely, M.D., and his alternate is Roy G. Wilson, M.D., both of whom are from Campbellsville.

Hawaii Medical Seminar Planned

The Hawaii Medical Association will sponsor a seminar from June 26 through July 1 immediately following the 1964 AMA meeting in San Francisco. The seminar will include four days of scientific sessions in Honolulu followed by a five-day workshop program on the neighboring islands of Kauai, Maui and Hawaii.

It will feature many prominent speakers, both local and from the mainland. Complete details on the meeting may be obtained by writing: Hawaii Medical Seminar, Suite 300, 1612 K St., Washington, D. C. 20006.

Locum Tenen Wanted:
July and August 1964.
General Medicine, Louisville Suburb.
Excellent Remuneration.
No Obstetrics or Surgery.
No night hours.
Call: L. J. Singerman, M.D.
8186 Dixie Highway
Pleasure Ridge Park, Tel. 921-1457

Registered Nurse — Permanent position with excellent starting salary; open immediately; requirements: assisting obstetrician with labor and delivery room care, in Cincinnati, Ohio hospital; previous obstetrical experience essential. Write Clayton L. Scroggins, 141 West McMillan, Cincinnati, Ohio 45219, or phone 961-8679.

Psychiatric Residencies for General Practitioners and Other Physicians in Practice for More Than Four Years

There is a position available in a three year, approved dynamically-oriented psychiatric residency program in a 500 bed, acute general hospital. Rotations through acute psychiatric receiving service, adult and child out-patient and in-patient services, and consultation service. Intensive supervision. Experience in both individual and group treatment. Active didactic program. Medical school affiliation and appointment.

Applications now being accepted for the academic year beginning July 1, 1964. N.I.M.H. grants up to $12,000 per year for physicians who meet the requirements of this program. For further information write: Alex H. Kaplan, M.D., Director of Training Program; Department of Psychiatry; The Jewish Hospital of Saint Louis; 216 South Kingshighway Boulevard; Saint Louis, Missouri — 63110.



San Francisco—the Perfect Opportunity to Mix Postgraduate Study With Pleasure!

Start the summer at the world's greatest medical meeting in America's most picturesque city. Now after six years the AMA returns with the outstanding scientific program of 1964. In just five compact days, you can make a comprehensive review of the most recent medical progress in general practice and **all** the specialties.

- **60** original papers on organ transplants and hyperbaric oxygen
- **6** general scientific meetings: diagnosis of acute liver disease, autoimmune mechanisms & disease, cardiovascular opacification, tumors of the endocrine function, hyperbaric oxygen phenomena, and computers in medicine
- **22** medical specialty programs
- **750** scientific and industrial exhibits
- **Special** program on heart disease by the AMA, American College of Cardiology, and the American Heart Association
- **Lectures, Panel Discussions, Motion Picture Premieres, Color Television**

All This, and San Francisco, too—and Don't Forget to Bring the Family!

JUNE 21-25 1964

◁ ◁ ◁ See JAMA May 9 for complete scientific program — Forms for advance registration and hotel accommodations ▷ ▷ ▷

You

CAN RECOMMEND
BLUE SHIELD
TO YOUR
PATIENTS



Because

BLUE SHIELD MEANS A SPECIAL KIND OF PROTECTION TO PEOPLE

Blue Shield has never cancelled membership because of age, health, retirement, or an incurable condition. May be transferred from one group to another—may be continued by retirees.

Kentucky Blue Shield offers a variety of Plans and broad range of benefits . . . on a voluntary basis . . . for families, individuals, and eligible groups.

BLUE SHIELD - BLUE CROSS

Medical - Surgical Protection

Companion Plan For Hospital Protection

KENTUCKY PHYSICIANS MUTUAL, INC.

BLUE CROSS HOSPITAL PLAN, INC.

3101 Bardstown Road • Louisville, 40205

Phone: 452-1511



IN THE BOOKS



OCCLUSION OF THE SUPERIOR MESENTERIC ARTERY: by Benjamin B. Jackson, M.D.; Published by Charles C. Thomas, Publisher, St. Louis, 1963; 141 pages; Price, $7.50.

This timely monograph is a good review of the pathogenesis of superior mesenteric artery occlusion. Only nine successful embolectomies have been reported, two of whom were operated upon by the author. The syndrome of stenosis of the superior mesenteric artery has also only recently been recognized; 15 such patients have been operated upon.

The cause of mesenteric occlusion in 1500 patients was embolism in 42 percent, thrombosis in 38 percent, and infarction without organic occlusion in 20 percent. The emboli usually resulted from atrial fibrillation. The thromboses developed from atherosclerosis in the proximal 4-5 cm. of the artery. The infarctions without organic occlusion occurred in patients with congestive failure and shock.

The author quite properly emphasizes that the diagnosis must be made principally from the history of severe pain and vomiting, for physical examination may show few abnormalities, except increased peristalsis, until peritonitis develops. Abdominal roentgenograms initially show no abnormalities.

The most feasible operations are either embolectomy or bypass graft. Other theoretical operations are briefly described.

The syndrome of stenosis of the superior mesenteric is discussed briefly, emphasizing post-prandial pain and weight loss. Diagnosis can be established by an aortogram performed in the lateral position. The simplest treatment is a bypass graft from the terminal aorta.

Extensive experimental work by the author is presented, describing the visual changes in the intestines with acute arterial occlusion by using the ingenious technique of replacing the anterior abdominal wall with a transparent plastic membrane.

An extensive bibliography is present, though numerical indices are not listed in the text. Good drawings illustrate the points presented. This monograph should serve as an excellent source of information regarding the pathogenesis and clinical diagnosis of mesenteric artery occlusion.

Frank C. Spencer, M.D.

PSYCHOLOGICAL DEVELOPMENT IN HEALTH AND DISEASE: by George L. Engel, M.D. Published by W. B. Saunders Co., Philadelphia, 1962; 435 pages; price, $7.50.

For a long time, practitioners of medicine and/or psychiatry have needed a book that would relate in a meaningful way the biological with the psychological. *Psychological Development in Health and Disease* is such a book. Doctor Engel has had rich experience in both the biological and psychological facets of patients and people. He uses this knowledge to weave a thoroughly documented book, bringing closer together the biologist and the psychologist.

While this book is written "mainly for medical students and psychiatric residents," it is not a textbook of psychiatry. Doctor Engel presents a holistic concept of disease and does not recognize a psychesoma dicotomy. He draws heavily on Cannon, Selye and Piaget to document his thesis. The psychological approach is in the classical psychoanalytic mold and is admirably related to biological changes.

Discarding the usual diagnostic approach, Doctor Engel attacks the problem of psychological disease from causation. This attack is more comprehensible and useful for the practitioner. It forces the examiner to view the patient and his disease rather than a description of his presenting complaint.

While there is a plethora of books available on normal and abnormal childhood, few comment on normal adult development. The sections on "normative development of the man" . . . and . . . "woman" . . . and . . . "family" are a significant contribution. The chapter on the family is of immediate practical significance for those who have any contacts with family conflict. Doctor Engel assumes a good deal of knowledge on the part of his reader. While most of his explanatory material is quite clear, some sections are unnecessarily complicated and wordy. The book is dead serious throughout and some case material would be a welcome relief.

This book is highly recommended for the serious student of Homo sapiens, be he medical student, resident, or practitioner.

Warren M. Cox, M.D.

'Hematologic' Tumors

Continued from Page 371

mustard and several of its derivatives, especially indicated in the treatment of lymphoma and lymphocytic leukemia, and antifolic agents and antimetabolites used mainly in acute leukemia. Corticosteroids, judiciously used, have a definite place as an adjuvant in the treatment of childhood leukemia and certain symptomatic aspects of leukemia and lymphoma, such as bleeding associated with thrombocytopenia, the "toxic" and febrile aspects of Hodgkin's disease and advanced lymphomas and the hypercalcemia of multiple myeloma.

Bibliography

1. Ward, C. G. and Hendrick, J. W., *Diagnosis and Treatment of Tumors of the Head and Neck* Williams and Wilkins-Baltimore 1950
2. Dargeon H. W., et al, *Hemangioma With Thrombocytopenia* J. Ped. 54, 285, 1959
3. Hoagland R. J., *Infectious Mononucleosis*—Blood 16, 1045, 1960
4. James, A. H., *Hodgkin's Disease With and Without Alcohol-Induced Pain* Quart. J. Med. 29, 47, 1960
5. Rush, B., et al, *Cancer of the Head and Neck in Children* Surgery 53, 270, 1963
6. Windholz F. and Foster S. E., *Bone Sclerosis in Leukemic and Non-Leukemic Myelosis* Am. J. Roentgenol. 61, 61, 1949

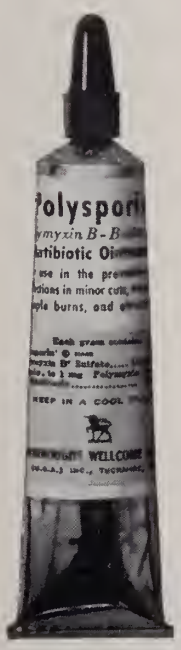
Dr. Weeter on Project Hope

John C. Weeter, M.D., Louisville plastic surgeon, left March 24 for Guayaquil, Ecuador, to join the medical staff of the teaching-training hospital ship S.S. Hope.

Doctor Weeter, a clinical instructor in plastic surgery at the University of Louisville School of Medicine, will serve for two months as a member of a rotating medical team aboard the Hope. Rotators serve without pay and augment the ship's permanent medical staff.

Madison, Indiana—WANTED: 2 General Physicians, July 1, 1964, in a fully accredited dynamically oriented Psychiatric Hospital. Minimum training—year internship. Citizenship and Indiana License required. Starting Salary $11,400. Complete family maintenance available at a very reasonable rate. Excellent opportunity for professional development in general medicine, neurology and psychiatry. Apply to: Ott B. McAtee, M.D., Superintendent, Madison State Hospital, Madison, Indiana.

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Supplied:** in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK®



Answers to Questions About Your Blue Shield

1. Q. Does Blue Shield make a payment for treatment of severe sunburn cases?

   A. It depends on the services rendered. There could be an individual consideration allowance authorized by the Medical Adviser.

2. Q. Does Blue Shield make a payment for "Exchange Transfusion" on an infant?

   A. Under Standard Blue Cross, an infant does not become a member until 30 days of age; however, special consideration can be given in such cases. Under Comprehensive Blue Cross, children are covered at birth and such a procedure would be covered.

3. Q. Does Blue Shield make a payment to the doctor for stomach lavage?

   A. This is given individual consideration.

4. Q. Does Blue Shield make a payment for routine infant care?

   A. No, not for routine care of a well infant.

5. Q. Does Kentucky Blue Shield provide an allowance for primary, secondary or delayed closing of a wound by any method other than suturing?

   A. Yes, Blue Shield provides an allowance for closing of wounds with surgical tape or butterfly bandage. Skin clips have always been acceptable. However, a detailed description of each wound should be included on the claim form (For example: the number of lacerations, the length of laceration, the location of the laceration).

6. Q. I have been unable to find an allowance in Schedules C & D for Diagnostic I-131 Uptake Test and Scanogram. Are these procedures covered under these Certificates?

   A. Blue Shield allows $15 for the I-131 Uptake Test and $10 additional payment when a scanogram is done.



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #22-62. This 35 year old gravida 4 para 3 was admitted on July 28, 1962 with hypertension (250/140), albuminuria, and pedal edema in the sixth month of pregnancy.

The history was given of staggering and falling out of bed, followed by seizures. In the emergency room she was noted to be disoriented. She had a grand mal seizure, but when she was seen by the physician, the contractions of the extremities had ceased, although the head was jerking and the eyes looked toward the left. The emergency room physician gave the patient 500 mg of sodium amytal intravenously and drew blood for a sugar determination. The blood pressure was 200/110, and the temperature, 100.2°.

The patient was admitted to the medical ward. She was extremely obese, and her pregnant status was not immediately realized. Two hours after admission, she was transferred to the obstetrical floor. At that time, the diagnosis of eclampsia was made. She was given magnesium sulfate and an apresoline infusion was instituted.

On July 29, 1962, at 9:30 A.M., the patient responded slightly to stimuli; the fetal heart beat was not heard at this time, and the patient was oliguric (465 cc in 21 hours). She was delivered of a 13 ounce, non-living fetus at 7:05 P.M. on July 31, 1962. After delivery, she seemed to improve; the blood pressure returned to normal, there was an increase in urinary output, and she became responsive to verbal stimulation.

On August 1, 1962, she developed diffuse râles in both lung fields, and her respiration was rapid and labored. At 9:30 A.M., the blood pressure was 110/70, the patient was responsive, and respirations were no longer labored. At 10:00 A.M., she had gasping respiration and was unresponsive. Immediately thereafter, there were no respiratory movements or heartbeat, and no pulse was palpable. Attempts at resuscitation were unsuccessful.

An autopsy was performed and the final diagnoses were: severe bilateral bronchopneumonia and pulmonary edema, tracheobronchitis, eclampsia (clinical diagnosis), mild generalized atherosclerosis, left ventricular hypertrophy, moderately severe cystitis, pseudomucinous cystadenoma of the right ovary, external hemorrhoids, uterine leiomyomata, paraganglioma, and focal perportal necrosis. The cause of death was acute bronchopneumonia and pulmonary edema secondary to eclampsia superimposed on chronic hypertensive cardiovascular disease.

Comments

The committee classified this case as a direct obstetric death with preventable features on the part of the patient, who had not presented herself for prenatal care prior to the onset of convulsions. The patient's obesity masked the existence of the pregnancy, and this fact accounted, no doubt, for the ill-advised choice of sodium amytal for initial control of the convulsions. The sudden pulmonary death was compatible with the bronchopneumonia and pulmonary edema observed at autopsy. Despite standard and rational therapy such as this patient received, occasional fatalities from eclampsia continue to occur, especially in fulminant cases early in the third trimester in patients with underlying hypertensive cardiovascular disease.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospitol Assaciation, Member Illinois Haspitol Associotian. Licensed by the Department of Public Health, State of Illinois.

MURFREESBORO - VACANCIES:

STAFF PHYSICIANS for 1275 bed neuropsychiatric hospital, including 350 general medical and geriatric. Modern facilities for diagnosis and treatment of mental illness. Salary $11,150 to $18,405 depending on qualifications; fringe benefits; cost of moving to Murfreesboro will be paid by Veterans Administration; visit here for evaluation can be arranged at our expense. Excellent educational opportunities for students in this area. Contact Director, Veterans Administration Hospital, Murfreesboro, Tenn.

NEW MEN'S SHOP



. . . in our **NEW SOUTHERN OPTICAL BUILDING**, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

GUILD OPTICIANS Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS — 1963-1964

GEORGE P. ARCHER, Prestonsburg ..... President
DELMAS M. CLARDY, Hopkinsville ..... President-Elect
DAVID M. COX, Louisville ..... Immediate Past President
CARLISLE MORSE, Louisville ..... Vice President (Central)
CARL C. COOPER, Bedford ..... Vice President (Eastern)
JOHN DICKINSON, Glasgow ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, Corbin ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
DOUGLAS E. SCOTT, Lexington ..... Chairman of the Board of Trustees
GABE A. PAYNE, JR., Hopkinsville ..... Vice Chairman of the Board of Trustees

DELEGATES TO THE A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

BOARD OF TRUSTEES

First District ..... O. LEON HIGDON, Katterjohn Building, Paducah 1965
Second District ..... HOWELL J. DAVIS, 330½ Allen Street, Owensboro 1964
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville (serving interim term) 1964
Eighth District ..... DON JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1964
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1964
Eleventh District ..... HUBERT JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... CLYDE C. SPARKS, Mayo Arcade, Ashland 1964
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

BUYERS GUIDE

JOURNAL OF THE KSMA BUYERS GUIDE FOR MAY, 1964

American Medical Association 406
Ames Company 415

Blue Cross Hospital Plan 407
Burroughs Wellcome 3S1-409

Chatham Pharmaceutical, Inc. 397
Coca-Cola Company 410

Geigy Pharmaceuticals 352
Gyne-Cytology Labs. 390

Jewish Hospital 405

The Keeley Institute 413
Wm. Kendrick Jewelers 396

Lederle Laboratories 349-395-403
Eli Lilly & Company 358

Madison State Hospital 409
Medical Protective Company 350
Medico Electronics Company 398

Mt. Holly Nursing Home 350

New Castle Sanitarium 410

Emerson A. North Hospital 348
Parke, Davis Company 342

A. H. Robins Company 3S5-392-393-402
Roche Laboratories 416

Clayton L. Scroggins 405
G. D. Searle & Company 387
Smith Kline & French Company 3S3
L. J. Singermon, M.D. 405
Southern Optical Company 413
E. R. Squibb & Sons 343

V. A. Hospital 413
John T. Vie Company, Inc. 397

Wallace Laboratories 347-3S6-357-389-399-401
Winthrop Laboratories 345



Don't feel sorry for **ACETEST**® Reagent Tablet — It still does a good job. But new, improved **KETOSTIX**® "dip-and-read" test for ketone bodies in urine, serum, or plasma, is more convenient. It's faster (only 15 seconds) and more sensitive. When you use **KETOSTIX** Reagent Strips you don't even need a medicine dropper. Simply dip and read **KETOSTIX** and get a more definitive detection of ketone bodies. Still like **ACETEST** Reagent Tablets? That's okay, but remember, we said, "**KETOSTIX** Reagent Strips are more modern." □ Ames Company, Inc., Elkhart, Indiana.

69964

AMES

anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety
anxiety reduced to its proper perspective

LIBRIUM®
(chlordiazepoxide HCl)
the successor
to the tranquilizers

ROCHE

In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment. Caution should be exercised in prescribing any therapeutic agent for pregnant patients. Supplied—Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.

JUNE 1964 • VOLUME 62 • NUMBER 6

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



COLLEGE OF PHYSICIANS
SEP 1 1965

In This Issue

The Allergic Emergency—Aftermath of Modern Therapeutics
Joseph H. Shaffer, M.D. 433

Perspective in Anesthesia
Jay Jacoby, M.D. 437

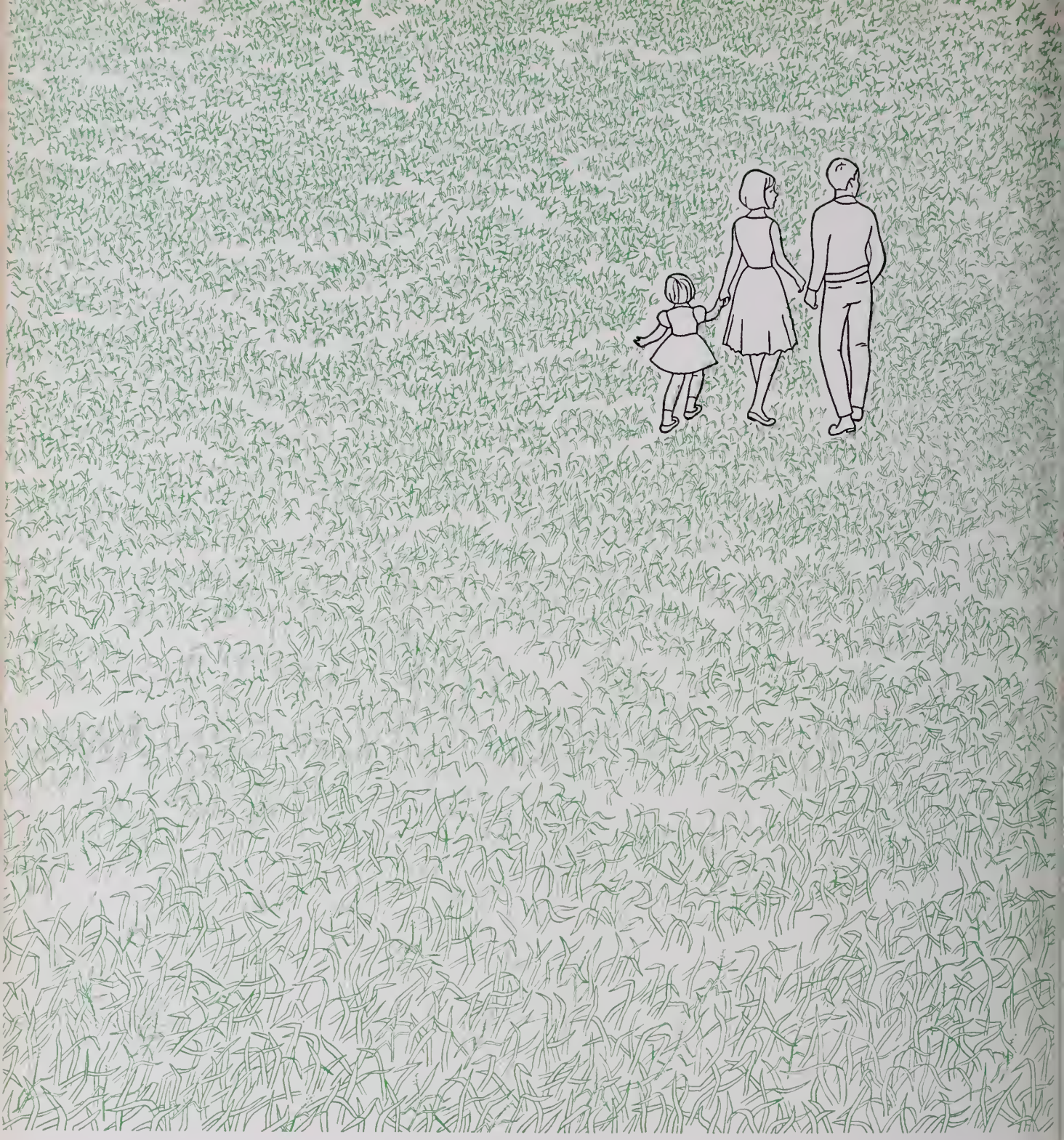
Stimulation of Ovulation
Philip S. Crossen, M.D. 441

Colonic Polyps: A Surgical Pathology Dilemma
E. J. Fadell, M.D., and Marvin A. Lucas, M.D. 444

Treatment of Benign Essential Hypertension
Sidney Roston, M.D. 447

Complete Contents on Page 420

KSMA Annual Meeting Sept. 29- Oct. 1
Convention Center, Louisville



pollens in the grass...alas

Kapseals®
Benadryl®
(diphenhydramine hydrochloride)

FOR EFFECTIVE CONTROL OF ALLERGIC SYMPTOMS—*Antihistaminic action* relieves nasal congestion, sneezing, lacrimation, and pruritus. *Antispasmodic action* relieves bronchial spasm. **Precautions:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers, if used with BENADRYL (diphenhydramine hydrochloride), should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENADRYL (diphenhydramine hydrochloride). BENADRYL (diphenhydramine hydrochloride) is supplied in several forms including Kapseals containing 50 mg. 39864

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

Announcing A New Series of Monographs . . .

MAJOR PROBLEMS IN CLINICAL SURGERY

J. Englebert Dunphy, Consulting Editor

Each volume in this series will exhaustively illuminate a significant problem met in surgical practice. Offering a consistently post-graduate level of presentation, the books will give comprehensive accounts of all aspects of their subject, to aid you in accomplishing the most successful surgical management possible today. Each eminently qualified specialist-author will present a critical analysis of changing approaches to therapy, of etiology, pathologic physiology, diagnosis and differential diagnosis. Operative techniques will be clearly described and illustrated. Operative and postoperative complications will be considered. Several volumes will appear each year, containing 150-300 illustrated pages. Future monographs will cover: *Polyps of the Gastrointestinal Tract; Trauma to the Liver; Surgical Problems of the Pancreas; Peripheral Arterial Disease.* By becoming a charter subscriber to the entire series, starting with the first volume, you are offered free examination of every book, with absolutely no obligation to buy even one volume. Merely check the appropriate block on the coupon.

The First Volume in the Series—Now Ready

The Liver and Portal Hypertension

by Charles G. Child, 3rd, M.D.

In this new monograph, Dr. Child and 12 collaborators present a complete picture of the nature of portal hypertension and its surgical management. You will find discussions of such vital surgical considerations as: *the effectiveness of portacaval and splenorenal shunts; selection of patients for operation; arguments for and against "prophylactic" shunt procedures in the patient with esophageal varices; relative advantages of end-to-side and side-to-side shunting.* Management of the patient with active bleeding esophageal varices is helpfully discussed. In addition, Dr. Child and his eminent collaborators evaluate current concepts of pathologic physiology of portal hypertension; they detail the essentials of medical and supportive management.

By Charles G. Child, 3rd, M.D., Professor and Chairman, Department of Surgery, University of Michigan Medical School. With 12 Collaborators from the Departments of Medicine and of Surgery of the University of Michigan and the Department of Surgery of New York University. About 224 pages, 6⅛" x 9¼". illustrated. About $7.50. *New—Just Ready!*

New!—Beard and Wood-MASSAGE PRINCIPLES AND TECHNIQUES

Here is an authoritative manual to help you become more skillful in utilizing the beneficial effects of massage—help in developing or regaining elasticity of tissues; stimulating blood supply; decreasing pain and discomfort; providing psychological stimulation to use disabled parts. The book is the final product of methods evolved from 35 years of experience with massage at Northwestern University Medical School. The well-known authors give you concise, well-illustrated and clearly defined instructions on *massage movements, on the components of massage—on equipment, position of patient, routine of treatment—on step-by-step techniques of general and local massage—on effects of massage on muscle tissue, blood, skin, bone, metabolism, abdominal viscera, etc.* They give advice on where and when massage can be used effectively—before and after surgery—for the prevention of decubital ulcer and muscle atrophy in the bedridden patient. You'll find help on *kneading, petrissage, stroking and effleurage, percussion, pressure, rate and rhythm, duration, frequency.* Advice on tables, mattresses, linen and pillows is also included. For practical help in utilizing and developing skill in massage, add this new manual to your library.

By Gertrude Beard, R.N., R.P.T., Formerly Associate in Physical Medicine and Technical Director, Course in Physical Therapy, Northwestern University Medical School; and Elizabeth C. Wood, A.M., R.P.T., Associate Professor of Physical Medicine and Educational Administrator, Programs in Physical Therapy, Northwestern University Medical School. About 176 pages, 7¼" x 10¼", with about 250 illustrations. About $6.00. *New—Just Ready!*

New!—1963-64 MAYO CLINIC VOLUMES

You'll find here the new treatments, surgical techniques, and diagnostic methods developed at the Mayo Clinic this past year. The Clinic's investigations covered virtually the entire body, including many specialty areas of practice: *Alimentary Tract—Genitourinary Tract—Ductless Glands—Blood and Circulatory Organs—Head, Trunk and Extremities—Dermatology—Thorax—Brain, Spinal Cord and Nerves—Radiology—Anesthesia, Gas and Intravenous Therapy.* For easier reference the articles (approximately 230) are organized into two separate volumes—one on **Medicine** and one on **Surgery.** Among the articles in the Medicine volume you'll find discussions on: *Pain Patterns of Gastric Disorders—A Simplified Menstrual Record—Reevaluation of Therapy of Acute Myocardial Infarction—Unusual Systemic Manifestations Associated with Carcinoma.* Articles in the Surgery volume include discussions of: *Considerations Relevant to Gastric Freezing—Transrectal Needle Biopsy as an Office Procedure—Conservative Surgical Management of Endometriosis—Pitfalls in Vein Surgery—An instrument for Colorectal Anastomosis Without Sutures—etc.* The books are available either separately, or as a slip-cased set. Why not put this practical, up-to-date advice from the Mayo Clinic to work in *your* practice?

Volume 55. By the Staff of the Mayo Clinic, Rochester, Minnesota, and the Mayo Foundation, University of Minnesota. Volume on **Medicine,** about 544 pages, 6" x 9⅛". illustrated. About $13.50. Volume on **Surgery,** about 560 pages, 6" x 9⅛", illustrated. About $13.50. Slip-cased Set about $25.00. *New—Just Ready!*

W. B. SAUNDERS COMPANY West Washington Square, Phila. 5, Pa. SJG 6-64

Please send and bill me:

☐ Easy Pay Plan ($5 per mo.)

☐ Child—*Liver & Portal Hypertension* . . . About $7.50
☐ Beard & Wood—*Massage* . . . . . About $6.00
☐ *1963-64 Mayo Clinic Volumes* . . . Set, About $25.00
☐ Medicine . . About $13.50 ☐ Surgery . . About $13.50



☐ Also enroll Me as "No Risk" Charter Subscriber

Name_____ Address_____

VOLUME 62 • JUNE 1964

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Sam A. Overstreet, M.D.

• ASSOCIATE EDITOR
Walter S. Coe, M.D.

• MANAGING EDITOR
J. P. Sanford

• ASST. MANAGING EDITOR
Ann M. Huntsman

• DEPARTMENTAL EDITORS
Jack L. Chumley, M.D., Scientific
Eugene H. Canner, M.D., Boak Reviews
Oscar J. Hayes, Case Discussians
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR
George F. Brackman, M.D., Chairman
Willett H. Rush, M.D.
Blaine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Moore, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1966
Horold L. Bushey, M.D.
Edword J. Fodell, M.D.
Merle W. Fowler, Jr.. M.D.
Joseph L. Goldstein, M.D.
John D. Lovett. M.D.
George F. McAuliffe, M.D.
Rolph G. Thomos, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965
McHenry S. Brewer, M.D.
Lewis Dickinson, M.D.
Zygmunt Gierloch, M.D.
Douglos L. Gillim, M.D.
Arthur H. Keeney, M.D.
Jomes B. Stith, M.D.
Chester B. Theiss, M.D.
Kearns R. Thompson, M.D.

Term Expires July 1, 1964
Herbert L. Cloy, Jr., M.D.
Orville T. Evons, M.D.
M. Rondolph Gilliom, M.D.
John Gordinier, M.D.
Fronklin B. Moosnick, M.D.
Williom Oldhom, M.D.
Howord W. Ripy, M.D.
Somuel M. Smith, Jr., M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205

Subscriptian $8.00—single copy .80

Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

The Allergic Emergency—Aftermath of Modern Therapeutics
Joseph H. Shaffer, M. D. 433

Perspective in Anesthesia
Jay Jacoby, M.D. 437

Stimulation of Ovulation
Philip S. Crossen, M.D. 441

Colonic Polyps: A Surgical Pathology Dilemma
Edward J. Fadell, M.D., and Marvin A. Lucas, M.D. 444

Treatment of Benign Essential Hypertension
Sidney Roston, M.D. 447

CASE DISCUSSION

Pregnancy Complicated by Congenital Spherocytic Homolytic Anemia and Cystic Teratoma of Ovary
J. W. Greene, Jr., M.D., Madison Cawein, M.D., and E. J. Lappat, M.D. 450

SPECIAL ARTICLE

The Pros and Cons of the Kerr-Mills Program in Kentucky
Warren County Medical Society and G. L. Simpson, M.D. 452

EDITORIALS

Credit to Whom it is Due 454
A Problem of Communication 455

ORGANIZATION SECTION

First Cammencement at U.K. College of Medicine 456
Top-Ranking Guest Speakers Feature of Annual Meeting 460
Twa Kentucky M.D.s to Take Part in AMA Scientific Pragram 460
Dr. Scott to Head SE Sectian of American Urologists 460
KSMA Trustee Districts Hold May Meetings 462
1964 KSMA Interim Meeting Sets Attendance Recard 462
First Mental Health Cangress Registration Tatals 153 463
Rural Ky. Schalarship Fund Grants New Laans to Eight 464
Dr. Witten New KAGP President; Academy Hanars Dr. Denham 464
Dr. Johnstan New President af Ky. Surgical Saciety 469
Ky. College of Surgeons Elects Dr. Rabertsan New President 469
Ky. Medical Assistants Install New Officers 474

REGULAR FEATURES

President's Page 422
In The Books 428
Postgraduate Page 470
Insurance Page 480
Public Health Page 482
Maternal Mortality 488

For the "modern Cinderella"

pHisoHex®

enhances any acne treatment



"...No other disease has caused so much feeling of inferiority" as acne.[1] pHisoHex "...is a valuable part of the management...since in addition to its defatting and cleansing properties, it offers an antibacterial action which reduces skin bacterial flora."[2]

In a series of 42 patients, none "...failed to improve," when pHisoHex was added for the wash.[3] In another series of 67, acne lesions "...cleared in a matter of one to two weeks" in 50 per cent with pHisoHex.[4] In another series of 100 patients using pHisoHex and pHisoAc®, 79 showed excellent or good improvement.[2]

The frequent exclusive use of pHisoHex enhances adsorption of its 3% hexachlorophene content to the skin; there it remains as a tenacious film to fight bacteria *between* washings. pHisoHex cleans thoroughly—is nonalkaline, hypoallergenic and "kind" to the skin. Three to four washings a day are needed for constant degerming of skin, faster and better results.

pHisoAc Cream dries, peels and masks lesions—helps prevent comedones, pustules and scarring. Contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent and hexachlorophene 0.3 per cent.

How supplied: pHisoHex is available in unbreakable squeeze bottles of 5 oz. and 1 pint, in unbreakable plastic bottles of 1 gallon and in combination package with pHisoAc Cream.

References: 1. Szymanski, F. J.: *Indust. Med.* 30:498, Nov., 1961. **2.** Wexler, Louis: *Clin. Med.* 70:404, Feb., 1963. **3.** Hodges, F. T.: *GP* 14:86, Nov., 1956. **4.** McLean, I. E. D.; Graham, K. T., and East, M. O.: *Practitioner* 189:82, July, 1962.

Winthrop

Winthrop Laboratories, New York, N. Y.



(1888-M)

MESSAGE FROM THE PRESIDENT



Your Delegates to the AMA

HAVE YOU given any thought to the responsibility of your elected delegates and alternate delegates from KSMA to the AMA? Do you know how much time it requires? Are you aware of how hard it is necessary for them to work? If you think being a delegate to the AMA amounts to sort of an expense-paid vacation twice a year—then, we would say, you are sadly misinformed.

The duties of the delegates and alternates tie them so closely to the activities of the AMA Headquarters Hotel, where the meetings of the House, the Reference Committees, hospitality room, and other functions are held, that seldom if ever has a delegate an opportunity to hear a scientific paper or visit the exhibits during the five-day session.

Traditionally in the Kentucky Delegation, the senior delegate serves as chairman. He presides at the caucuses, makes Reference Commitee assignments, serves as chief host and operator of the hospitality room, instructs the staff and ties all the loose ends together. All delegates, alternates, officers and staff and other KSMA members are invited to attend the three caucuses the delegation holds.

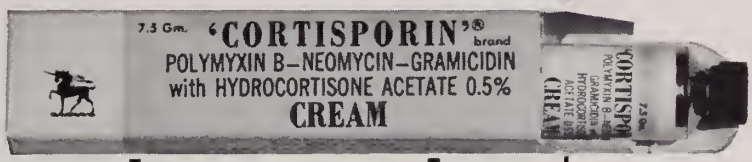
Members of our delegation have been assigned to the Reference Committees they are to cover at the AMA Annual Meeting June 21 to 25. They will do their homework, attend the Reference Committee meetings, then report to the entire delegation on what took place at the committee they covered at an early morning caucus before the first meeting of the House. These same delegates and alternates are now being asked to serve as resource people in our own KSMA Reference Committee meetings.

What about KSMA's prestige in AMA? Only a few years ago we had no representation in the AMA other than our delegates. We now have a KSMA member on the AMA Board of Trustees, a member on one of the councils and seven or eight on AMA committees. We salute our KSMA Delegation to the AMA. We are proud of their contributions, which are growing in significance at all levels.

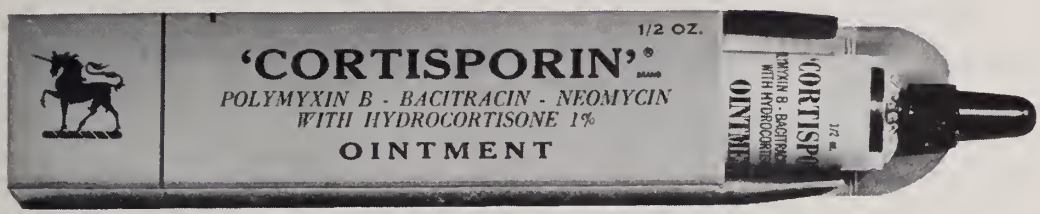
George O. Archer M.D.

P.S. These delegates and alternates are very eager to bring to you the AMA story. They await a call from your Couny Medical Society to discuss this with you.

CHOOSE THE PRODUCT TO FIT THE NEED



a new vanishing cream base



a special low melting point base

anti-inflammatory
bactericidal
antipruritic
rarely sensitizing

CREAM—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) 5.0 mg.; Gramicidin 0.25 mg.; Hydrocortisone Acetate 5.0 mg. (0.5%).

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, distilled water, and 0.25% methylparaben as preservative.

Available: In tubes of 7.5 Grams.

OINTMENT—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Hydrocortisone 10 mg. (1%).

In a special white petrolatum base.

Available: In tubes of ½ oz. and ⅛ oz.

*U.S. Patent Nos. 2,565,057–2,695,261

Indications: Wherever inflammation or infection occurs and is accessible for topical therapy.

Contraindications: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

Caution: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



After Surgery: B and C vitamins are therapy

Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS, designed to meet increased metabolic demands, aids in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

7202-4

The case of diaper rash



solved by NEW UNDERCOVER AGENT

BAKER'S **CREME**

DIAPER-SIL™



CONTAINS : panthenol, benzalkonium chloride, dimethylpolysiloxane, in a water-miscible cream base.

eliminates ammonia-splitting bacteria. The bactericidal component, benzalkonium chloride, has a proven record of effectiveness. It acts rapidly against a wide range of organisms implicated in diaper rash — including Brevibacterium ammoniagenes and Alcaligenes faecalis.

soothing, healing, protective. DIAPER-SIL also provides panthenol in a special base containing silicone . . . helps to soothe inflamed skin, protect from external irritants and gently promote healing.

TO HELP PREVENT AND TREAT DIAPER RASH, CHAFING AND SIMILAR CONDITIONS

BAKER LABORATORIES, INC. Cleveland, Ohio 44115

Subsidiary of U.S. Vitamin & Pharmaceutical Corp.

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator — MARGARET KELLY, R. N., Director of Nurses



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK (R)



one of the fundamental drugs in medicine

Smith Kline & French Laboratories

SK&F



DRUGS OF CHOICE, 1964-1965: edited by Walter Modell, M.D. Published by the C. V. Mosby Co., St. Louis, 1964; Modell, is the fourth edition of a volume that first **1018 pages; price, $16.75.**

Drugs of Choice, 1964-1965, edited by Walter Modell, is the fourth edition of a volume that first made its appearance in 1958. The fact that the editor and publishers have gone to the trouble to put out a fourth edition apparently indicates that the book is at least a commercial success.

The editor's preface describes the work as "a practical guide to the selection of the best drug for a particular therapeutic problem, . . . a volume of expert opinion designed to provide the American physician with a comprehensive source of clear, concise, authoritative, and practical answers to the continually recurring question of which drug in a rapidly changing scene is, at the critical moment, the drug of choice for an actual therapeutic problem." To achieve these ends, the talents of forty-seven authors have been utilized, and a volume of forty-one chapters and 1018 pages (including index) has been compiled. These statistics are impressive, but the book is not.

Drugs of Choice is certainly not concise or clear—excess verbiage fills almost every page. It is certainly not practical—for a complete therapeutic regime is seldom given for any drug. I cannot even agree that it is authoritative, in spite of the famous names in the list of contributors for authoritative opinion is buried under a "say a kind word for drugs" attitude that prevails throughout most of the book. Instead of giving us their candid opinion on the usefulness of a certain drug, the authors usually hand us an extensive parade of the same old platitudes, designed, it seems, so as not to offend anyone by making any direct statements.

This sort of bitter fate awaits most books of multiple authorship. However talented the parents, the offspring of such a multiple marriage of abilities almost invariably gets his genetic material badly scrambled and emerges into the world as in this case, a poor mixture of Cecil's Textbook of Medicine, the United States Pharmacopea, and the Merck Manual.

The book does have its share of peaks and valleys which make the otherwise dull landscape a bit more bearable. Notable high points include the editor's introductory chapter dealing with general applications of clinical pharmacology, and chapters by Leroy D. Vandam, M.D., on the management of hypotension and shock and by Robert Lich, Jr., M.D., on the use of drugs in urologic disorders. This last mentioned chapter is one of the few in which candid opinions are clearly expressed. Valleys are almost too numerous to menton, but the chapter on drugs for the treatment of poisoning undoubtedly represents the deepest, with chapters on anesthetics and drugs for the relief of pain running as close seconds.

A volume of this type would be all together useless without a good index, and this is divided into two sections, a drug index that is a help in sorting out the many trade names, and a general index. The latter lists many obscure conditions and unusual drugs, but some of the more common items are a bit hard to find. For example, if one seeks advice on the management of pre-menstrual tension, it will be found listed as "molimina, pre-menstrual."

This reviewer does not feel that practitioners of medicine will find enough useful information in *Drugs of Choice, 1964-1965* to justify the expenditure of $16.75, and believes that institutional libraries could also find a better use for their always limited funds.

Donald M. Thomas, M.D.

VAGINAL HYSTERECTOMY: by Laman A. Gray, M.D., published by Charles C. Thomas, Springfield, Ill.; Second Edition, 1963; 228 pages; price, $9.50.

This is the second edition of Doctor Gray's well-known monograph on vaginal hysterectomy, first published in 1955. As was the first edition, it is an authoritative treatise on the history, indications, operative technique and follow-up of vaginal hysterectomy.

Of especial value are the chapters on indications for vaginal hysterectomy and on operative technique, for in them the author provides a distillation of the knowledge and experience with this procedure which have earned for him his position as a practicing gynecologist of the first rank.

Since the first edition, the author has added a chapter summarizing various operations that have been proposed for uterine prolapse as well as a very short chapter on radical vaginal hysterectomy. The latter is very abbreviated and superficial, since it falls outside the personal experience of the author as of most American gynecologists.

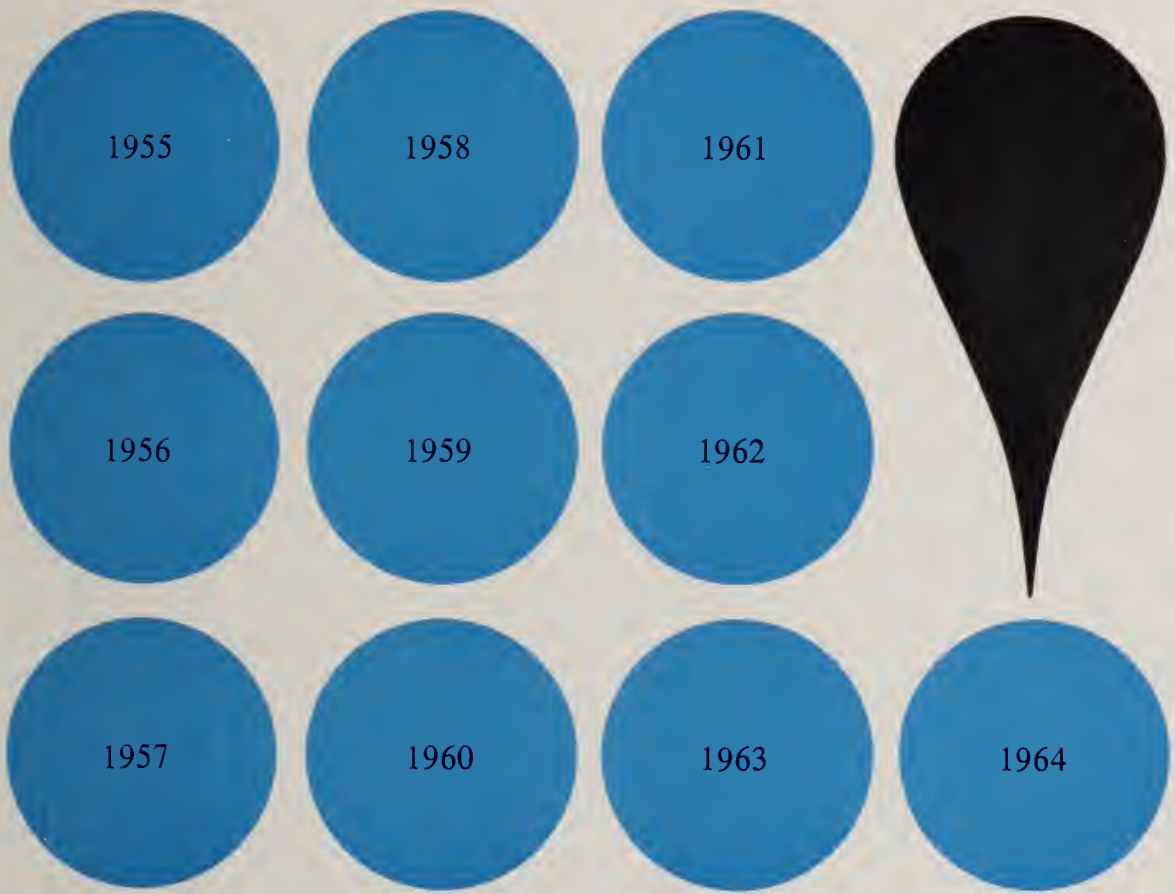
The book is attractively printed and bound, and continues to offer excellent illustrations of the operative technique described. Every illustration in this second edition is either new or has been redrawn with additional clarity in mind, and the overall effect, already very good in the first edition, is impressive indeed.

The book is heartily recommended for careful study by residents in training in gynecology as well as by gynecologic surgeons, to whom it may well suggest useful points in tecnique.

The introductory summary of the operation's historical background contains a number of fascinating items that are probably little known to most operators. Dr. Gray is to be complimented on providing the profession with so worthy a successor to his splendid first edition.

Douglas M. Haynes, M.D.

The clear conclusion from 10 years' experience...



belongs in every practice

Miltown®
(meprobamate)

CM-2026

WALLACE LABORATORIES/Cranbury, N. J.

THE DERMATOSES THAT WERE STEROID-UNTREATABLE

Salt and water retention, edema, overstimulation of the appetite, excessive weight gain, mood swings—these were some of the problems that used to confront physicians when they wanted to prescribe steroids for dermatoses. For patients already overweight, or with edema associated with cardiovascular disease, or those who were tense and anxious, steroid treatment could aggravate their problems. But with the advent of ARISTOCORT® Triamcinolone, many of these patients became "steroid-treatable." The reason: Not only did *this* steroid provide gratifying symptomatic relief, but it did so *without* the penalty of overstimulation of the appetite, excessive weight gain, salt and water retention, edema, and undesirable euphoria. And these benefits have been confirmed for other patients with steroid-susceptible disorders, as well as those formerly untreatable.



Side Effects: Since it may, under some circumstances, produce many of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.
Contraindications: While the only absolute contraindications are tuberculosis, herpes simplex and chicken pox, there are some relative contraindications (peptic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.
A single daily dose may provide effective control, is convenient for the patient, and can be employed in both initial and maintenance therapy.

MAXIMUM STEROID BENEFIT—MINIMUM STEROID PENALTY

Aristocort®

Triamcinolone

1 mg., 2 mg., 4 mg. or 16 mg. tablets

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

272-4





Putting the cap on a bottle sounds simple. Just make it tight enough to keep the contents in, prevent leakage, and protect the product; loose enough to be opened with ease. However, that isn't quite as simple as it sounds. ■ At Eli Lilly and Company, there are exact-tightness specifications for the cap of every bottle. Capping machines are carefully adjusted to apply just the right amount of torque (or twist) to tighten the caps. Then the tightness of the caps is double-checked . . . just to be sure. ■ That's where the torque tester comes in. At least once every fifteen minutes, five bottles are tested as they come out of the capping machine. They are placed on the torque tester, and the twist on the caps is measured . . . just one more of the many controls that add immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

400654

The JOURNAL of the
Kentucky State Medical Association

Issued Monthly Under the Direction of the Board of Trustees

VOLUME 62 JUNE, 1964 No. 6

The Allergic Emergency———

Aftermath of Modern Therapeutics†

Part 1*

Joseph H. Shaffer, M.D.**
Detroit, Mich.

Allergic reactions to newer diagnostic and therapeutic aids are recognized with an ever-increasing frequency. Caution is recommended when selecting chemicals, drugs and biologicals for the study and treatment of patients.

A NEVER-ENDING list of new drugs now available has made a tremendous impact on the practice of medicine as we know it today. These drugs in a sense have simplified and, at the same time, because of toxicity, idiosyncrasy, or allergy, have complicated our efforts in patient care. In certain instances following their use, we are confronted with new clinical problems which are in a sense "man-made diseases." Anaphylactic shock, polyarteritis nodosa, asthma, lupus erythematosus, hepatitis, nephrosis, acute urinary retention, phocomelia, convulsive disorders, hemotoxic drug reactions, antibiotic and steroid-induced conditions are but a few of those recently reported in the medical literature.[1,2,3,4,5,6,7,8]

Following the introduction of diphtheria antitoxin by von Behring, Richet coined the word, "anaphylaxis" to explain sudden death in laboratory animals previously sensitized and subsequently challenged with foreign sera. This phenomenon of hypersensitivity is not limited to the use of foreign sera in the laboratory, since there is hardly a diagnostic or therapeutic agent at our disposal today which at one time or another has not been incriminated in the production of hypersensitivity or allergic reactions in patients we have under treatment.

The possibility of an allergic emergency of the constitutional or anaphylactic type confronts all physicians, regardless of their special fields of practice. We are in a sense caught "off guard" since such episodes may follow procedures we have used many times, and involve medications which are not necessarily new to us. Those reactions that develop over a period of hours or days; i.e., delayed response to penicillin or tetanus antitoxin, permit us time to cope with the situation—this valuable ingredient (time) is denied us, however, in handling the acute emergency which strikes with little or no warning and with lightning-like swiftness. A matter of a few seconds or minutes is the differential between life and death. Consideration of all potentialities of this problem would require more time than is at my disposal today. I will, however, attempt to present, more or less

†*Presented at the annual meeting of the Kentucky Academy of General Practice at Louisville, May 8, 1963.*
**Due to the length of this article, it will be run in two parts, the second of which will appear in the July issue of The Journal of KSMA.*
***Chief, division of Allergy, department of Medicine at Henry Ford Hospital, Detroit, Michigan.*

in outline form, an approach from an allergist's viewpoint.

As we write prescriptions, administer injections, or perform diagnostic or therapeutic procedures, there is reason enough to ask ourselves several questions. Is this medication, or procedure really necessary? Do I know the ingredients in this capsule or pill? Is this preparation likely to be anaphylactic because of its gredients in this capsule or pill? Is this preparation likely to be anaphylactic because of its chemical structure? Can I substitute another medication which carries less risk of sensitization? Is the therapeutic objective sufficient to warrant the calculated risk involved? The "Physicians Desk Reference," or "The Medical Letter" are valuable source references should we be in doubt as to the medications we select for our patients.

A few months ago we presented data on the subject which is under discussion today. We listed diagnostic and therapeutic "pit falls" likely to be encountered in our every day office practice, reviewed the immunologic mechanisms involved in allergic reactions to drugs, and considered measures that might prove useful in the prevention and treatment of allergic reactions.

Diagnostic Pitfalls

Patients often give histories of violent responses to foods, drugs, and medications. Such substances as mustard, eggs, nuts, shellfish, horse serum, cat dander, penicillin and acetylsalicylic acid are frequently incriminated. It is often prudent to document the records with this information and forego tests which, in themselves, carry a high risk of constitutional reactions.

All too often the patient with multiple allergies spread over several groups of substances (foods, animal epidermals and pollens) will, if tested en masse, explode with severe reactions of the constitutional, or anaphylactic type. This response can usually be avoided by conservative "block" testing, i.e., the application of foods one day, animal epidermals another day, with the pollens left for still another test session.

An allergist soon recognizes those substances which may be expected to react with vigor, and therefore uses conservatism in the selection of substances to be applied to test sites. Test sites on the inner aspect of the forearm or on the anterior thigh permit application of a tourniquet to aid in slowing down absorption from a rapidly developing test and makes it possible to inject epinephrine above the tourniquet, or into the opposite extremity.

Conservative testing by the scratch technique often gives a full blown response to test substances such as animal danders and pollens. Should the scratch tests be inconclusive, intradermal testing with a 1:100,000 solution of extracts may produce vigorous whealing with pseudopods and erythema. Stronger serial dilutions may be required to obtain a positive test, in an effort (which should always be made) to correlate test patterns with the history, or, as a method of titrating for safe starting hyposensitizing doses.

Intradermal tests with extracts are more than a hundred fold more reactive than are scratch tests with dried powders. Care should be exercised in their utilization.

Following constitutional or anaphylactic episodes, there may be a refractory period of some 10-14 days. Tests during this period may be negative and therefore misleading. On the other hand, tests applied too soon after an attack of acute asthma may precipitate another episode, more difficult to bring under control than was the original attack. It is often prudent to delay testing for several weeks following an acute asthmatic attack.

When reporting to the clinic for protein testing, it is imperative that patients not be medicated with sympathomimetic drugs or antihistamines which partially block the immediate whealing response. Conversely, steroids may block the delayed, or tuberculin-type of reaction to bacterial, molds and house dust extracts.

All too often, patients tell us that they have been tested in the past and were found to be allergic to "everything." This statement suggests the presence of dermatographia which masks the true response, i.e., the wheal, pseudopod, and erythema (Triad of Lewis) required for interpretation of a test as positive. In order to eliminate confusion in interpreting tests, control tests must be applied.

Therapeutic Pitfalls

In a busy office with numerous vials of extracts on hand, through human error, *the wrong vial* may be used to fill an injection syringe. Checks and double-checks in selection of vials (plainly labelled as to contents and

strengths of solutions) cannot be too rigorous.

Intravenous therapy carries with it the greatest risk of anaphylaxis. Accidental penetration and injection of substances, such as pollen extracts, directly into a vein is a constant concern of the allergist. Pressure over the puncture site, prompt application of a tourniquet above the area, and a syringe filled with epinephrine within arm's reach, puts one in readiness to deal with a potentially emergent situation.

When *fresh vials of pollen extracts* are removed from refrigeration and placed on the treatment trays, they are usually more potent than those which have been exposed to room temperature for several weeks. "Shading" the dose of fresh extract will often prevent a reaction, especially in those individuals whose dosage has been maintained at a border line maximum level of tolerance.

The *level of tolerance* is often reached without warning. Every care should be taken to avoid over-treatment. As the stronger pollen extracts are used, it may be best to "split" doses rather than boldly follow a standard scale which calls for increases. The leveling off point for administering pollen extracts is so variable in patients that this dosage level should be approached with caution.

Maintenance doses of pollen extracts should be reduced by several levels during pollen seasons, to compensate for exposure of the patient to pollen present in the air.

If a patient, on a two week treatment schedule is *late for his appointment* and extends the interval to three or four weeks, reactions may be avoided by reduction of dosages.

In an attempt to reduce local reactions, or to permit injection of larger doses of pollen extract, it has been advocated by some to "freeze" the arm with an ice cap to slow absorption, or to include injectable antihistamine or epinephrine with the pollen extract. This results in confusion and certainly "masks" one's effort to arrive at a well tolerated treatment dosage level.

Injections of medicines should be given in areas which permit application of tourniquets. The gluteal area, or high deltoid area precludes use of a tourniquet; the outer portion of the upper arm is the injection site of choice.

Patients often receive pollen therapy for protection during several of the pollen seasons, i.e. trees, grasses, weeds. For perfect control of dosage levels, we use separate injection sites for each pollen extract. The dosage of ragweed pollen extract may need to be increased, while others may require a decrease. After maximum tolerated doses have been determined, we find combining of pollen extracts quite feasible.

In hot and humid weather, when the patients' skin is moist and skin capillaries are dilated, absorption may be accelerated. Reduction of the dosage level may avoid reactions. When a patient, receiving a series of bacterial or viral vaccines, reports for treatment and has an acute respiratory infection, it is best to treat the infection and defer vaccine therapy until the infection is under control. Schedules for the administration of pollen extract, under such circumstances, however, may be maintained. Reports[9] indicate that fractional doses of polyvalent influenza vaccine are sufficient for the production of protective antibody levels. Such doses tend to eliminate uncomfortable local reactions which may be followed by chills, fever, and a precipitated bout of influenza following this immunizing procedure.

Immunology of Drug Allergy

An ideal drug, according to Berryman,[10] would be absorbed without alteration of its molecule, would exert one specific action on one enzyme system of the body, would be released after its effect is completed, and finally, would be eliminated, without change, through existing channels of excretion. In order to become active, most drugs undergo biotransformation, or metabolic changes, for solubilization, absorption, passage across the lipoid membrane of the cell, for therapeutic effect and eventual secretion. They are altered during penetration of the lipoid membrane which separates the intestinal tract from the bloodstream, or, at the lipoid barrier which protects the cells of the target tissue. When the body is challenged with an unnatural chemical, reactions may develop through unexpected and undesirable interaction of the chemical with cellular enzymes. The chemical may interfere with or inactivate an enzyme system which participates in normal physiological regulations. There may be formation of metabolites, or partial degradation products of the drug, which are capable of combining with protein tissue components to form haptens. Such hapten body-protein conjugates (antigens) are capable of stimulating antibody production. The formation of antibodies is the initial step in the sequence of events which

can lead to antigen-antibody union which in turn causes allergic reactions. Following primary exposure to a drug, and, after a subsequent incubation period and re-exposure to the same drug (or one closely related chemically) antigen-antibody reactions with allergic response, occur at the cellular (or possibly intracellular) level.

Incidence of Drug Allergy

In preparation for a clinic presentation on drug allergy, a survey was made of the records of 101 patients seen during one outpatient day (taken at random). There were 40 instances of drug sensitivity caused by 16 different drugs in 16 patients for an incidence of 15.8 per cent in this group of allergic individuals. Several patients had experienced reactions to as many as six different drugs. Glaser,[11] in a review of 500 children, 360 allergic and 140 non-allergic, found an incidence of drug allergy of 20 per cent in the first group and around 2 per cent in the second.

There is no way of knowing the true incidence of drug allergies. Penicillin ranks first among the offenders, closely followed by sulfonamides and compounds containing acetylsalicylic acid. It is estimated that 50 per cent or more of the population has been exposed to penicillin, either by therapy, or by its presence in milk and other dairy products. Between one and two per cent of all people who have received penicillin become allergic to penicillin and cannot safely receive it again.[12] At least two to three million people have had reactions to this drug, some of which have been serious, others fatal.[13] It is estimated that one in six of those patients with an allergic history will eventually develop penicillin sensitivity. In speaking before the Midwest Forum on Allergy in 1958, I pointed out that up to that time there were 1,000 documented deaths due to anaphylaxis from intramuscular injection of penicillin. Since that time I have administered no injections of this drug.

Quinn et al,[14] treated 27 consecutive patients with penicillin-susceptible streptococcal endocarditis (considered to require parenteral penicillin) with oral Penicillin V. He suggests that oral penicillin therapy for this condition, however, requires monitoring of the adequacy of intestinal absorption of penicillin by determination of serum inhibitory activity in each patient. With this limitation the oral route may be substituted for the parenteral, thus avoiding poor patient tolerance, local thrombophlebitis, pain, inflammation, and the added risk of anaphylaxis associated with intramuscular therapy. Reports of reactions to drugs other than penicillin, i.e., vitamin B1, chymotrypsin, antihypertensive agents, tranquilizers, antidiabetic, antithyroid agents, theophylline, ACTH, etc. are appearing with alarming frequency in current medical literature.[15, 16, 17]

To be concluded in the July issue of The Journal

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Perspective in Anesthesia†

Jay Jacoby, M.D.*

Milwaukee, Wis.

During the first 100 years, anesthesia underwent little change. Then developments came at an accelerated pace. Present practice is evaluated and some predictions for the future are made.

AGONIZING reappraisal always occurs when unexpected harm results from an apparent improvement. Two recent episodes in therapeutics have called for a reappraisal in the testing and use of drugs. The catastrophic results of thalidomide have caused an upheaval in the pharmaceutical industry and the government regulatory agency. A tempest in a teapot has been caused by a numerically insignificant incidence of liver failure attributed to halothane.

Whether or not halothane is actually responsible for the small number of liver injuries, a question is raised. As anesthesiologists, where are we headed?

For one hundred years anesthesia remained relatively stagnant. Only a few drugs were known, and many anesthetists limited themselves to the use of one or two, or perhaps at the most three agents. The mechanical equipment involved was either non-existent or of the utmost simplicity. The individual who administered anesthetics in 1847 would have felt quite at home with the anesthetics of 1947. At least, in many a small hospital and in some large hospitals, he would have found that the drugs and techniques were identical.

The New Face

But change was already under way: a plethora of new drugs, equipment of unbelievable complexity, techniques requiring physiologic knowledge as well as manual dexterity. These have given the new face of anesthesiology since World War II. The old G.P. anesthetist either has retired or has been frightened away. He has been replaced by the specialist who understands pharmacology as well as electronics. He has been replaced by the super-specialist and his team of investigators, who not only administer anesthetics but conduct physiologic research of basic nature.

The goals in anesthesia have changed. For the first hundred years the anesthetist tried to keep the patient reasonably quiet on the table, and to see that he did not remember the surgical episode. In obstetrics only the latter was required; if the patient moved about she would push the baby out more rapidly.

In the mid-twentieth century the anesthesiologist is bewildered by his new found power. A specialist in short supply, he is engaged in a struggle to define his sphere of influence, establish professional prestige, and obtain public acceptance. Lost somewhere in the struggle to keep up with every new development is the old axiom "primum non nocere".

Every new drug, every new technique, every piece of equipment is obtained and tried out. Instead of doing a splendid job in the same way that it was done the last time, each new innovation must be tried. No one of us wishes to attend his local society meeting and admit to his colleagues that he has not yet had experience with the latest development.

The fact that more harm than good can come from this attitude, does not appear to receive much consideration. New is equated with good, and change is equated with progress. It is difficult to see what can be gained by the anesthesiologist of the small community hospital trying out every innovation.

With a little reflection, most people would agree that the team of experienced investigators conducting a controlled project can and do make contributions to progress. This does not mean that the practicing anesthesiologist necessarily must utilize the results of the first published preliminary paper. Nor should the prac-

†*Presented at the meeting of the Kentucky Society of Anesthesiologists during the Annual Meeting of the Kentucky State Medical Association at Lexington, September 24-26, 1963.*

**Professor and chairman of the department of Anesthesiology at Marquette University School of Medicine, Milwaukee, Wisconsin.*

ticing anesthesiologist try out the samples of all the new drugs offered to him by representatives of the pharmaceutical houses. Let the investigators conduct intensive studies, repeated time after time by themselves and others, until the evidence is overwhelming that the innovation is not only valuable but safe, and that whatever hazard may be introduced is more than compensated for by the elimination of hazards of the alternate technique.

The practicing physician responsible for the safety of individual patients must bear in mind that the published results of research projects must be examined with a critical eye. Too often, the data are gathered and the observations are made by untrained or by unreliable individuals. In fact, many a paper is written by a professor who draws conclusions from faulty data and inaccurate observations gathered by a first year resident from another country. The double blind study and statistical analysis have not been sufficient to eliminate erroneous conclusions.

In every specialty of medicine, the practicing clinician exhibits greater wisdom by utilizing drugs and techniques which have served reliably in the past, rather than trying every new one which is suggested. This is particularly true in the field of anesthesia, where we can take it for granted that any substance which is claimed to be an anesthetic agent, whether regional or general, will in fact produce anesthesia. Whether it produces anesthesia more safely than other drugs is the question which can only be determined by detailed studies and large series of cases.

We do not intend to say that the practicing clinician should entirely avoid the use of new substances. Indeed, he may in fact be the best individual to evaluate something new, because he is already competent, and his observations are not clouded by ignorance or by errors due to lack of technical ability. For such an individual, however, there is a difference between casually trying a new drug, and conducting a well thought out research project.

The Goal

The goal of the anesthesiologist may be simply stated: to provide good operating conditions for the patient and the surgeon, without causing harm. A number of ramifications may be elaborated from this simple goal.

For the patient, there should be freedom from pain. Less important but very desirable are the relief of anxiety, dissociation from the environment, freedom from nausea and pain postoperatively. For the surgeon, such rapidity of induction and emergence that no time is lost in starting, and in changing from one case to the next; a motionless operative field in which the viscera are contracted and the muscles are flaccid. The anesthesiologist should prevent the patient from bleeding, and if bleeding does occur he should provide for stability by suitable blood transfusions. The anesthesiologist takes personal pride in his abilities to provide a pleasant induction, a perfect unobstructed airway, pulmonary ventilation that is more than ample, bright red blood in the operative field, completely flaccid musculature, and prompt restoration of consciousness as the last suture is placed.

The attempt to provide each of these desirable qualities may cause some added risks for the patient. The drug which provides freedom from anxiety may also depress the respiratory center. The desire for rapid induction may lead to profound hypotension, as a result of the rapid rise in the blood level of the anesthetic agent. The harm may be caused by intravenous injection or by pulmonary hyperventilation, using a potent agent. The flaccid musculature is provided at the expense of the patient's ability to breathe. Not only is the patient subjected to the harmful effects of positive pressure, and hyperventilation, but he may also be left with muscular weakness in the postoperative period. The attempt to diminish bleeding by hypotensive techniques or to diminish oxygen demand by hypothermia may cause complications due to inadequacy of circulation in the vital organs. The maintenance of a normal blood volume in the face of massive blood loss may introduce a large number of complications which result from blood transfusions.

Everything which the modern anesthesiologist does, adds to the possibility of difficulty, danger or death for the patient. The new local anesthetic agents each may provide some slight advantage in rapidity of onset or duration, but until the maximum dose for the human has been determined some instances of overdosage may occur. Such a simple thing as the insertion of an endotracheal tube, done with the best of intentions for the preservation of the airway, may result in death due to axphyxia, because of inability to get the tube in or numerous complications caused by trauma. Relaxant drugs so

freely used to provide cadaveric musculature may cause a fatality due to hypoxia or hypercarbia either during or following the operative procedure.

To what extent is modern anesthesia justified? There is no accurate information regarding morbidity and mortality decades ago. Man's memory is short, particularly for unpleasant events. Nevertheless, we often hear older surgeons state that the frequency of operating room deaths has markedly increased during the past few years. The advances in drugs, technology, monitoring equipment, and physiological knowledge do not seem to have diminished the death rate attributed to anesthesia. That we operate upon many more poor risk individuals and do more major procedures, is not pertinent, when we consider the number of relatively young healthy individuals who become statistics.

Medical knowledge cannot be purchased. But the application of funds and energy to any scientific problem can lead to rapid resolution. Some of the problems in anesthesia offer fewer difficulties than those which pertain to space travel. Solutions to our problems should be available.

Future Needs

The ideal anesthetic agent may never be found. We are looking for a substance which combines the virtues and eliminates the defects of drugs now available. Like nitrous oxide, it should have rapid action and disappearance, and it should be non-toxic, non-irritating, and non-explosive. Like cyclopropane, it should be potent and allow for good tissue oxygenation. Like ether or succinylcholine it should provide muscular relaxation which is readily reversible. A feature which is not available in any anesthetic agent, it should have no cardiac effect. The search for the ideal general anesthetic agent goes on. Although the fluorinated hydrocarbons are in the spotlight, future interest may well turn to another chemical group. Or attention may be directed to physical means of producing anesthesia, by electricity, magnetism, sound, light, or pressure. We may turn to drugs which produce general analgesia without unconsciousness, or regional analgesia without injections.

Monitoring equipment has come to dominate our thinking in the last decade. It is costly and impressive in appearance. It enhances our prestige by impressing the observer. As a research tool, monitoring equipment has been very helpful. For ordinary use in clinical situations, monitoring equipment has been disappointing. Aside from cost, the equipment is cumbersome, troublesome, and unreliable. It diverts the attention of the anesthesiologist from his patient. It is misleading: malfunction may cause needless alarms on the one hand, or give a false sense of security on the other. What we need is equipment cheap enough to be available for every patient, miniature and as easy to apply as a blood pressure cuff, reliable and without trailing wires. Telemetering appears to be the applicable principal. Furthermore, the equipment should tell us about the things that are important, namely cardiac output, organ perfusion, true blood volume, and blood gas concentration. And since a resident engineer is not built in, utmost simplicity should be.

Resuscitation should come under scrutiny both as to method and applicability. The heart is a rhythmic organ; it beats continuously unless something stops it, or the ravages of disease prevent its further function. Cardiac arrest caused by a sudden physiologic change may be reversible. When the heart stops because of a severe disease state, resuscitation efforts are unlikly to be fruitful. A high incidence of successful resuscitation in young or healthy individuals should be regarded more as an indictment than a compliment, since in such cases the cardiac arrest probably should not have occurred.

Since our goal in anesthesia is to make it possible to get the operation done without harm to the patient, let us discuss a few of the things being done at Marquette University to further this aim. It is not intended that these ideas be immediately adopted by anyone; in fact, please do not try them!

Current Projects

The hyperbaric chamber appears to be of particular value in the management of patients with such conditions as carbon monoxide poisoning, coronary occlusion, congenital heart disease, intestinal obstruction, and shock. We are fortunate to have one of the pioneers in the field, Edgar End, M.D., who is working on the adaptability of this method of therapy to surgery and anesthesia.

A recurring problem for anesthesiologists is the management of the patient with food or blood in his stomach. Some patients and some

operations are unsuitable for regional anesthesia. Some patients are not cooperative for awake intubation. We have attempted to solve this problem by giving the patient succinylcholine and thiopental simultaneously, after denitrogenation has been accomplished. As the drugs take affect, the respiratory efforts rapidly disappear; regurgitation may occur but aspiration cannot. A cuffed endotracheal tube is immediately placed and general anesthesia is induced. Questioning in the postoperative period indicates that three quarters of the patients have retrograde amnesia for the entire event. One-fourth of the patients have some recollection of tightness in the muscles, inability to breathe normally, or something being done to their mouths. None of the patients considered the experience to be unpleasant, painful, or disagreeable. None of the patients regurgitated or aspirated.

Hypoventilation in the postoperative period may result from the residual effects of drugs given during the operation, or from narcotics given after, or from splinting due to pain. Breathing machines require that a well fitting mask be continually kept on the patient's face, or that a tracheotomy be done, in itself a procedure not without complications. There are many pitfalls which prevent the satisfactory use of breathing machines. Endeavoring to find a simple solution to this problem we have used continuous insufflation of moistened oxygen through a transtracheal catheter. With the orifice of the catheter placed near the carina, turbulance should assist in the ventilation of the alveoli. Anesthetized and paralyzed animals were treated. In some instances, we were able to maintain normal blood pH and gas tensions in apneic animals for a period of one hour. A transtracheal catheter in a postoperative patient might aid in maintaining gas exchange even though pulmonary ventilation is below normal.

Pulmonary embolism is a problem of increasing frequency with advancing age of the population. The occurrence of a massive embolism during the course of an operation usually places the anesthesiologist under a cloud until an autopsy provides clarification. If permission for autopsy is not granted however, the diagnosis cannot be made with certainty; the suspicion always lingers that the fatality was caused by the anesthetic. We have worked out a technique for verifying the presence of a pulmonary embolus even if permission for an autopsy is not obtained.

Summary

Great progress has occurred in our specialty as a result of the aggressive pursuit of knowledge. Research in anesthesiology has made great contributions to physiology, pharmacology, and surgical progress. We have not yet had sufficient time to assimilate all of these advances so that they can be judiciously applied when indicated. As a matter of fact, the wisdom of the clinician may be more evident in his withholding rather than utilizing a particular entity.

For the future we can look forward to the development of drugs with less inherent toxicity. On the other hand, the judicious use of those we now have available permits us to accomplish virtually everything required for surgical care. Improvement in the management of particular problems may depend more upon acquiring greater skill, than upon development of new drugs. With reliable monitors which provide us with useful information, anesthesiologists may be better able to maintain homeostasis. If the ultimate outcome of the procedure is unfortunate, the proven diagnosis will permit us to learn more about cause and prevention. In addition to excellence in the care of our own patients, clinical anesthesiologists can make a great contribution by influencing other young physicians to enter our specialty so that skilled care can be provided for everyone.

Mark Your Calendar

for

September 29, 30, and October 1

KSMA Annual Meeting, Convention Center, Louisville

Stimulation of Ovulation †

PHILIP S. CROSSEN, M.D.
Lexington, Ky.

Failure of ovulation is a very difficult problem in the infertility patient. Many avenues of attack have been attempted, including those at the level of the thyroid, adrenal, ovary, and, most recently, the hypothalamus and pituitary.

Mechanism of Ovulation and Etiology of its Failure

THE importance of the hormonal axis between the anterior pituitary and the ovaries in the production of ovulation has long been known. Experiments demonstrating a higher control, namely the hypothalamus, have more recently been carried out in experimental animals. In reflex ovulators, ovulation may be prevented by the injection of an anticholinergic or an adrenergic blocking agent into the hypothalomus at proper times after copulation. In cyclic ovulators, the same agents will block ovulation if given on certain days of the proestrus. Conclusions from these experiments are that the hypothalamus produces cholinergic followed by adrenergic stimulation to cause the output of gonadotrophins by the anterior pituitary.

The pituitary must be able to receive and act upon this stimulation in order to produce the proper gonadotrophins, which in turn act upon the ovary to produce an ovum containing follicle. The ovary must not only be able to produce this follicle but must be able to extrude the ovum from its surface to send it on its way to fertilization in the tube.

Implicated by many authors in the failure of ovulation have been not only these three points on the axis, but also, in some cases, the thyroid and adrenal glands as well.

The incidence of persistant anovulation in females in the childbearing age group has been shown in different series to vary between 2-6%. Anovulation manifests itself in menstrual behavior in various ways. In a few women, menstrual regularity may be undisturbed. Generally, there is menorrhagia alternating with long periods of amenorrhea, and in a few anovulatory women, there is total amenorrhea.

Anovulatory behavior is generally discovered in a workup for infertility, and therapy for it is usually directed toward the correction of that infertility. However, there may be reasons for attempting to correct the condition in younger women before the infertility has become the chief complaint. The first of these is the fairly well grounded fear that long term unopposed estrogen may produce malignancy of the endometrium. The second is a recent theory that the polycystic ovary of Stein-Leventhal may have its etiology in the younger anovulator.

Diagnosis of anovulation may be made by basal body temperature charting, lack of progesterone effects on the vaginal and cervical smears and subnormal amounts of urinary excretory products of progesterone over a protracted period. Investigation of the etiology of the anovulation consists of ruling out the thyroid and adrenal as the cause and then differentiating between the ovary and the hypothalamus-pituitary. This latter may be done by testing the 24-hour urinary output of follicle stimulating hormone (FSH), and output of estrogen by the ovary. High FSH output and low ovarian function (as in the menopause) indicates ovarian failure. Low FSH output and low ovarian function would point to pituitary or hypothalamic inadequacy.

Therapy

A. Thyroid

It has been shown that normal ovarian function requires a near euthyroid condition. Certainly a thyroid hypo or hyperfunction should be corrected if found in the workup of an anovulatory patient. However, the empirical use of exogenous thyroid in the euthyroid patient only suppresses the production by the gland of the cells without maturation of the follicles. In com-

†*Presented at the meeting of the Kentucky Obstetrical and Gynecologic Society during the Annual Meeting of the Kentucky State Medical Association September 24-26, 1963.*

endogenous hormone, and the end result is the same amount of circulating hormone. Also, harm may be done by precipitating a hypothyroid state temporarily when the drug is stopped.

B. Adrenal

Overproduction by the adrenal glands of androgenic hormones in congenital or acquired adrenal hyperplasia will suppress ovarian function, causing anovulation. There may even be signs of virilism, but the 17 keto-steroids in the urine may be quantitatively normal or only slightly elevated. This is due to the fact that only 10% of the androgens produced are excreted in the urine as keto-steroids. Hence, 10 mgms. of one of the more potent androgens may be released into the bloodstream, and will produce an insignificant rise of only 1 mgm. in the total 17 keto-steroids in the urine.

The rationale for the use of cortisone in the treatment of over-production of androgens by the adrenal glands is that this exogenously given hormone will suppress the production of the adrenocorticotrophic hormone by the pituitary and hence decrease the production of all components of adrenal cortical output. The exogenous cortisone itself will replace the glycogenic and electrolyte regulating hormones, thus giving an effective decrease in only adrenal androgens. This relieves the antagonism to ovarian estrogens and the normal pituitary-ovarian axis is restored.

C. Ovary

The typical polycystic ovaries of the Stein-Leventhal syndrome are sometimes found in those cases in which there is failure of the ovaries to extrude ova at regular intervals in the face of normal pituitary function. Rationale for the treatment of these cases by wedge resection or medullary resection of the ovaries is beyond the scope of this paper. However, surgery of this kind has met with fair to good success in restoring ovulatory cycles in a number of series.

The success in the production of ovulatory cycles in some women by the empirical use of radiation to both the ovaries and pituitary cannot be denied. However, those that use it must accept the danger inherent in direct exposure of chromosomal material to ionizing radiation. A mutant gene is produced which is always recessive. Thus the phenotype of this abnormal gene will show up only by a chance mating in a future generation.

D. Hypothalamus and Pituitary

A few cases of hypothalamic anovulation have responded to the injection of procaine into cervical ganglia. This is thought due to paralysis of the sympathetic innervation to the hypothalamus, thus rectifying hypothalamic-pituitary activity by allowing unopposed parasympathetic activity.

In selected cases in which anovulation is thought to be on a psychogenic basis, psychoanalysis has been successful in initiating or restoring normal ovulatory cycles. These individuals selected had all shown a lack of healthy maternal identification.

Recently, two chemicals have received attention as possible stimulators of ovulation. The first is labelled MER-25, which is known to be anti-estrogenic in experimental animals. Chemically it is a triphenylethylene derivative and in small series, one-third of anovulatory women showed signs of ovulation within a week after starting the medication. The substance is also known to be antizygotal, thus decreasing the chances of successful implantation should conception occur. The second chemical, MRL-41, or chloramiphene, has been successful in producing ovulation in a greater percentage of cases. The drug must be discontinued as soon as there is a rise in the basal body temperature, or a persistant corpus luteum will be formed. There have been reports of huge ovarian cysts being formed while using this drug, and one which ruptured with fatal results.

Some workers have attempted to give very large doses of estrogen in hopes of triggering the release of luteinizing hormone by the pituitary which does occur in experimental animals. There are reports of rise in basal body temperature and production of secretory endometrium by such therapy. However, there has been no consistant response to the use of estrogen and/or progestins in the female who has been anovulatory for six months or more.

For the past several years, considerable experimentation has been done using gonadotrophic extracts from serum and urine of humans and experimental animals and from autopsy pituitary extracts. Extracts from pregnant mare serum given to the anovulatory human female will cause follicle development but no corpus luteum. Human chorionic gonadotrophin extracted from the urine of pregnant human females will cause luteinization of theca

cells without maturation of the follicles. In com-bination, these two have caused complete ovulation. Their use is limited by the rapid formation of antihormones and lack of repeat ovulation on further administration.

In monkeys, follicle stimulating hormone and luteinizing hormone have been separated in anterior pituitary extracts. Using these in proper sequence, ovulation may be produced with regularity in anovulatory monkeys. Thus far, attempts to separate these gonadotrophic hormones in the human have been unsuccessful. The use of the monkey material in humans has met with very little success due to species specificity and anti-hormone formation. In attempts to simulate the use of the naturally occuring hormones, extracts of human autopsy anterior pituitary have been used and found to have a follicle stimulating hormone effect. This in combination with human chorionic gonadotrophin with its luteinizing hormone effect produced ovulation proven by the usual indirect criteria plus the indisputable criterion of pregnancy. Of interest is that all pregnancies achieved have been multiple.

In place of the direct extract from the pituitary, the use of gonadotrophins from the postmenopausal urine has been attempted. If successful, this would be advantageous as this material is more easily obtained and less expensive.

Summary

The most promising of the agents for stimulation of ovulation appear to be some of the newer chemicals and various extracts of the pituitary and chorionic gonadotrophins. The ideal method would be the use of all of the pituitary gonadotrophins themselves in the proper sequence and dosage, but this can only be simulated until all of these hormones can be extracted as separate entities.

References

1. Buxton, C. L. and Herrmann W.—*Induction of Ovulation in the Human With Human Gonadotrophins.* Yale Jour. of Biol. & Med. 33:145, October 1960
2. Buxton, C. L.—*Anovulation Due to Pituitary Failure.* Proc. of the Royal Soc. of Med. 54:297, April 1961
3. Buxton, C. L.—editor—*Therapeutic Irradiation: A Symposium.* Fertil. & Steril. 9:177, March-April 1958
4. Christian, C. D.—*The Neuro-Endocrine Control of Ovulation: A Review.* Bull. Sloane Hosp. Women 7:1, Spring 1961
5. Garcia, C. R., Harrigan, J. T., Mulligan, W., and Rock, J.—*The Use of Estrogens and Gestogens to Enduce Human Ovulation.* Fertil. & Steril. 11:303, May-June 1960
6. Gemzell, C. A., Diczfalusy, E., Tillinger, G.—*Clinical Effect of Human Pituitary* FSH. J. of Clinical Endoc. and Metab. 18:1333, 1958
7. Gemzell, C. A.—Colloquia on Endocrinology. Ciba Foundation XIII, London, 1960. J. and A. Churchill, Ltd. p. 191
8. Gemzell, C. A.—*Induction of Ovulation with Human Pituitary Gonadotrophins.* Fertil. & Steril. 13:153, March-April 1962
9. Greenblatt, R. B.—*Chemical Induction of Ovulation.* Fertil. & Steril. 12:402, September-October 1961
10. Kotz, H. L. and Herrmann, W.—*Induction of Human Ovulation I. Introduction and II.* Thyroid. Fertil. & Steril. 12:96, January-February 1961
11. Kotz, H. L. and Hermann, W.—*Induction of Human Ovulation III.* Estrogen. Fertil. & Steril. 12:196, March-April 1961
12. Kotz, H. L. and Herrmann, W.—*Induction of Human Ovulation IV.* Cortisone. Fertil. & Steril. 12:299, May-June 1961
13. Kotz, H. L. and Hermann, W.—*Induction of Human Ovulation V.* Gonadotrophins. Fertil. & Steril. 12:375, July-August 1961
14. Kotz, H. L. and Herrmann, W.—*Induction of Human Ovulation VI. A Review of Non-Endocrine Methods.* Fertil. & Steril. 12:493, September-October 1961
15. Rakoff, A. E., Potrowski, Z. A. and Loftus, T. A.—*Psychogenic Anovulation.* Fertil. & Steril. 13:1, January-February 1962
16. Simpson, M. E. and Van Wagenen, G.—*Induction of Ovulation with Human Urinary Gonadotrophins in the Monkey.* Fertil. & Steril. 13:2, March-April 1962
17. Simpson, M. E. and Van Wagenen, G.—*Induction of Multiple Ovulation in the Rhesus Monkey.* Endocrinology 61:316, 1957
18. Tyler, E. T., Olsen, H. J. and Gotlieb, M. H.—Int. J. of Fertil. 5:429, October-December 1960

KSMA Annual Meeting Sept. 29 - Oct. 1
Convention Center, Louisville

Colonic Polyps: A Surgical Pathology Dilemma†

Edward J. Fadell, M.D.,* and Marvin A. Lucas, M.D.**
Louisville, Ky.

The clinician is confronted with conflicting data on the cancerous potential of the colonic polyp. In the individual patient a wait and see policy is not feasible. A review of the pros and cons is given with suggested management.

In 1958, Spratt, Ackerman and Moyer[1] presented statistics tending to discredit the theory of the origin of adenocarcinoma of the colon within adenomatous polyps. They noted that the frequency distributions of adenomatous polys and cancers in the colon are not homogenous. In their study adenomatous polyps were shown to have a more even distribution throughout the colon than carcinoma. Polyps associated with single cancers within the rectum or sigmoid were more often located proximal to their respective cancers, and those cancers in the right side of the colon had polyps more often located distal to the respective cancer. If polyps become cancerous then the relative position of a cancer and its associated polyps should be random. In the review, they excluded villous papillomas of the colon in that they are relatively rare, are found with but few exceptions within the rectum and sigmoid and when sectioned serially, are often found to contain infiltrative carcinoma. They excluded the benign pseudopolyps of ulcerative colitis as these do not give rise to carcinoma because they lack epithelial cells excepting about their peripheries. Juvenile or retention polyps are believed to have no relationship to carcinoma of the colon, and are considered unanimously as benign tumors.

In the same year, Dockerty[2] of the Section of Surgical Pathology of the Mayo Clinic, made the following statement: "Probably no benign process exists in which a greater incidence of malignant change occurs than seen in colonic polyps. Eventually, 100% of these lesions become malignant."

in 1962, Benjamin Castleman, and Herbert Girckstein[3], reviewed their series. In their introductory paragraph, they stated that of all the problems currently facing the surgeon and the pathologist, none is more controversial than the pathogenesis and proper treatment of adenomatous polyps of the colon. They further pointed out that the stalk of the polyp has led to considerable controversy over what constitutes a true stalk and whether there is invasion of the stalk. To qualify a lesion as having a true stalk, one should be able to move the head of the polyp freely in all directions through a 90° arc without exerting any traction whatever. A lesion on a stalk may be a polyp, a papilliary adenoma or a polypoid carcinoma, but the great majority are polyps. They also stated that whatever the histology of a stalk lesion, the prognosis is much better when a stalk is present. At the Massachusetts General Hospital, there has never been an example of metastasis from a lesion on a stalk, even when the histologic study showed a polypoid carcinoma. They did not intend to infer that it is impossible for a polypoid carcinoma on a stalk to metastasize, but they considered the occurrence to be extremely rare. It was their firm belief that carcinoma very rarely developed in adenomatous polyps and metastasis from such a lesion is a curiosity if it ever occurs. They found only one instance out of a total of 322 polypoid lesions of a true focus of carcinoma occurring in an adenomatous polyp.

Observation vs. Surgery

Joel W. Baker[4] editorially stated that all patients seen at the Mason Clinic in Seattle, Washington, with gastrointestinal symptoms, and the majority of the patients referred for

†*Presented at the meeting of the Kentucky Society of Pathologists during the Annual Meeting of the Kentucky State Medical Association at Lexington, September 24-26, 1963.*

**Assistant professor of pathology at the University of Louisville School of Medicine, Louisville, Ky., and Pathologist, Methodist Evangelical Hospital.*

***Assistant professor of Proctology at the University of Louisville School of Medicine, Louisville, Ky. Also Methodist Evangelical Hospital.*

complete examination, are given proctoscopic examination. Five percent of these are found to have polyps, and 14% of these polyps have been classified as malignant. His comments on treatment were limited to the colonic polyp discovered above the reach of the sigmoidoscope. When the danger of malignancy has to be balanced against the risk of surgical laparotomy, it is their policy in the physiologically aged or very poor risk patient with a small solitary polyp, to have roentgenographic follow-up examination for suspicious increase in size. It is their feeling, barring such extreme cases, that the patient who has been fortunate enough to have a polyp discovered should have the benefit of early removal. It is further believed that rather than simple polypectomy, sleeve resection should be accomplished, thereby removing the primary regional lymphatics as well as a segmental length of "vulnerable mucosa."

In response to this article, Castleman and Kirchstein[5] stated in June, 1963, that they believed Baker's statements and opinions were misleading and contributed to a faulty perspective in dealing with a polyp-cancer problem. The advocacy of intestinal resection for an adenomatous polyp was considered radical and unwarranted. They reiterated it was virtually impossible to find documentation in the literature of metastasis from a tumor on a stalk. Also, they considered it unnecessary to worry about regional lymphatics from a lesion that virtually never became malignant in the sense of producing metastasis and death. To remove large segments of the intestine prophylatically on the basis of the vulnerable mucosa theory was considered to have no built-in limits as to when or where the surgeon should start or stop. It was their feeling that if the radiologist could document the presence of a true stalk beyond any reasonable doubt and if the lesion was asymptomatic, one could safely follow the patient. Without this assurance from the radiologist, however, they felt that laparotomy and simple colotomy with removal of the lesion was indicated.

In June, 1963, Rosser[6], writing on adenomas of the colon, stated that when the pendulum was swinging through wide arcs, the truth may lie in the happy mean of the center of the swing. It was pointed out that those who still respect the adenoma and are opposed to the present trend toward "watchful waiting" with annual or semiannual checking by barium enema do so, first, because they are still impressed by the similar age, sex incidence and distribution in the bowel of cancers, second, because satellite polyps are found in frank carcinomas in more than one-fourth of reported cases, the third because minute foci of invasive cancer in all stages of cancer development are found in the grossly unaltered adenomas.

Criteria of Pathologists

Helwig and Barbosa[7] in 1959, stated that pathologists frequently disagree in their interpretation of a given specimen. They cite the example of a case in which the microscopic slide of a polyp was sent to three eminent pathologists. They received three different diagnoses, namely, atypia, cancer-in-situ, and adenocarcinoma. They further pointed out that if one may judge from photomicrographs published in the literature, the criteria of most pathologists regarding cancer in rectal polyps are much too vague to be of practical value to the surgeon. They noted that atypia in the form of pseudostratification of nuclei, frequency of mitoses, crowding and elongation of epithelial cells, lack of secretory activity, basophilia and hyperchromasia are often wrongly interpreted as adenocarcinoma. It was concluded that from a clinical standpoint, only invasion of the submucosa can be accepted as a definite criteria of malignancy to be treated by radical surgery. They pointed out that small size, or the presence of a pedicle, is no guarantee that a given polyp is benign. Regardless of a clinically benign appearance, every polyp should have an adequate biopsy before it is destroyed by fulguration.

In reviewing Spratt, Ackerman and Moyer's[1] article, Bentley Calcock, commented that he felt the problem of the colonic polyp had an analogy with carcinoma of the thyroid in that the evidence was good that carcinoma of the thyroid begins as carcinoma and does not represent malignant degeneration in a previously benign adenoma. Therefore, the firm rounded nodule in the thyroid, although it may have remained stationary in size for years, may actually have been a papillary carcinoma from the onset and should be removed for that reason, rather than because it is a benign adenoma which may become malignant. Also, in that there is no way of distinguishing a polypoid carcinoma from a benign adenomatous polyp without

histologic examination, he felt they should be searched for and removed. Other wise, an opportunity to detect carcinoma of the colon at a very early stage might be missed.

In response, Doctor Moyer conceded that he just did not know what to do about adenomatous polyps of the colon, especially those above the region of the sigmoidoscope. He felt more study and time were necessary for the formulation of proper principles of treatment.

The recent text by Ackerman and Del Regato[8] states that of lesions smaller than 1.5 cm., only 13 were found to be malignant in a total of 1,016 tumors. The operative mortality rate attendent upon transabdominal removal for such lesions, was considered greater than the occurrence of malignant tumors among the small polyps. However, for lesions between 1.25 and 1.97 cm. in diameter there was a 12% occurrence of carcinoma and the incidence rose to 100% in all lesions over 3 cm. in diameter. They suggest that any radiographically demonstrated polypoid lesion of the large bowel, larger than 1.25 cm. and beyond the reach of the proctoscope, deserves to be treated as carcinoma, preferably by colonic resection.

Comment and Conclusions

From this brief review, all seem to agree that the adenomatous polyp constitutes a surgical pathology dilemma, at least as concerns management. A reasonable approach would be for the surgeon to be fully cognizant of the terminology used by his reviewing pathologist. Both must understand the classification used and its significance. Following this understanding, application of the principles elucidated by Grinnell and Lane[9] with modificiation, would seem applicable. Colotomy with polypectomy has a very definite place in the treatment of benign lesions of the colon. If the lesion is pedunculated, shows no gross evidence of cancer, such as induration or ulceration, colotomy with polypectomy should be sufficient. However, if a permanent section pathology report shows frank invasive carcinoma, a second operation must be considered.

Concerning a sessile polyp, local excision with scalpel should be done. If frozen section or later permanent histologic sections show invasive cancer, wider resection must be seriously considered.

Concerning rectal lesions, frozen sections are rarely needed since adequate information usually can be obtained by preoperative biopsies. Here snare removal of pedunculated adenomatous polyps and selected benign papillary adenomas is justified. If frank invasive carcinoma is reported following microscopic study, radical resection is indicated. However, if the invasive cancer is limited to the head of the polyp having a definite pedicle, no further therapy is needed.

Larger villous adenomas require scalpel excision. If invasive malignancy is found, radical surgery is required.

These recommendations are based on the following pertinent observations supporting the precancerous nature of the adenomatous polyp:

1) The age of patients at the peak incidence of adenomatous polyps is from seven to eight years lower than that of patients with carcinoma. This age differential is similar to that of the differential between intramucosal and invasive cancer of the cervix.

2) Focal epithelial changes which could be called unquestionable carcinoma in situ are very rerely, if ever, seen in normal mucosa. These changes are frequently seen in the epithelium of adenomatous polyps and papillary adenomas.

3) A definite relationship exists between the size of an adenomatous polyp and the incidence of secondary invasive cancer.

In conclusion, to quote Stearns[10], "It appears that essentially the only tiny cancers of the rectum found clinically are in adenomas, and that the de novo, tiny sessile cancer, while it does occur, is certainly too infrequent to explain the origin of the majority of carcinomas of the rectum and colon."

References

1 Spratt, John S., Ackerman, Lauren V., and Moyer, Carol A.: *Polyps of the Colon and Colonic Cancer.* Ann. Surg., 148:682-698, 1958.

2. Dockerty, Malcolm B.: *Pathologic Aspects in the Control of Spread of Colonic Cancer.* Proc. Staff Meeting, Mayo Clinic, 33:157-181, 1958.

3. Castleman, Benjamin, and Kirckstein, Herbert 1.: *Do Adenomatous Polyps of the Colon Become Malignant?* New England J. Med. 267:469-475, 1962.

4. Baker, Joel W.: *Polyps of the Colon,* Editorial, Surg. Gynec. & Obst. 115:496-497, 1962.

5. Castleman, Benjamin, and Kirckstein, Herbert, Surg. Gynec. & Obst. 116-752-753, 1963.

6. Rosser, Curtice: Editorial, South. M.J. 56:691, 1963.

7. Helwig, C. A., and Barbosa, E.: *How Reliable is Biopsy of Colonic Polyps?* Cancer, 12:620-624, 1959.

8. Ackerman, Lauren V., and Del Regato, Juan A.: Cancer, 3rd Ed., C. V. Mosby Co., 1962.

9. Grinnell, Robert S., and Lane, Nathan: *Benign and Malignant Adenomatous Polyps and Papillary Adenomas of the Colon and Rectum. An Analysis of 1,856 Tumors in 1,335 Patients.* Internat. Abstr. Surg. 106:519-538, 1958.

10. Stearns, M. N.: *Where are the tiny Carcinomas of the Rectum?* Editorial, Surg. Gynec. & Obst. 116:635, 1963.

The Treatment of Benign Essential Hypertension

Sidney Roston, M.D.*
Louisville, Ky.

Drugs alone do not adequately control benign essential hypertension. However, by lowering blood pressure, they facilitate psychotherapy. The resultant decrease in emotional tension may eventually lead to normal blood pressure without any necessity for drugs.

ASSOCIATED with the elevated blood pressure of benign essential hypertension ordinarily is some degree of increased emotional tension.[1] Decrease in tension is an important aim of successful treatment for this type of hypertension. Indeed, drugs do not lower blood pressure satisfactorily, in the author's experience, unless the emotional factors simultaneously come under control.

From this point of view the importance of the blood pressure reading lies in the fact that it provides an objective measurement of the degree of emotional tension. Reduction of tension is often not easy. By permitting the patient to re-experience sensations of reduced tension, lowering of blood pressure with hypotensive drugs facilitates development of insight into the sources of, and methods of handling, the increased tension. This report presents a typical case of the author's experience.

Case Report

A married, Caucasion female of 45 years sought medical attention on October 6, 1961, because of three to five hot flushes a day and heavy menstrual flow every 28-31 days for approximately six months. Until the onset of these complaints, she had felt well. She worked as a floating cashier in a large department store, shifting frequently from one department to another in accordance with personnel needs. Her 53 year-old husband was a bookkeeper. She had one daughter, who supported three small children by two divorced husbands through public relief funds and the undependable income from various waitress posts briefly held. Review of systems and past history were non-contributory.

On physical examination the patient was a heavy-set female who appeared to be her stated age and did not appear ill or particularly tense. Her weight was 165 lbs., height 63 inches. Casual blood pressure[1] in the sitting position in both arms averaged 220/135, heart rate 76 beats per minute. The fundi showed class two changes in the Keith-Wagener classification. The heart was normal on examination. The lungs were clear to percussion and auscultation. All arterial pulses in the feet were easily palpable. The uterus and adnexal organs were normal. The physical examination was otherwise unremarkable.

After persistence of the blood pressure elevation was established during the following week, laboratory studies were undertaken. The blood count and blood urea nitrogen, potassium, and 17-hydroxycorticosteroids were normal. And intravenous pyelogram was unremakable. A Regitine (Ciga) test was negative. A cervical smear showed no abnormal cells. The patient was placed on Rautrax-N-Modified, (Squibb), one tablet tid, and gradually increasing doses of guanethidine (Ciba). When her intake of guanethidine reached 50 mgm each morning, her blood pressure averaged 160/88, in the sitting position and 170/98 supine. The menorrhagia was rapidly controlled with 5 mgm of Halotestin (Lilly) twice a day during the few days of heavy menstrual flow. Several weeks of therapy with Tace (Merrill), 12 mgm twice a day, caused the hot flushes to disappear.

The patient felt well for five months. During this period she learned, with the aid of psychotherapy, to enjoy the reduced tension associated with a lower blood pressure level. At 9:00 A.M. on March 3, 1962, dizziness and weakness were present for 30 minutes, with relief in the supine position. The patient's blood pressure was 115/75 sitting and 140/95 supine, pulse 92. The guanethidine was de-

*Assistant professor of medicine at the University of Louisville School of Medicine, Louisville, Ky.

creased to 25 mgm each morning, and the orthostatic hypotension did not recur.

On May 8, 1962, she sought medical attention because of nervousness and difficulty in sleeping. From her sensations of tension, she was certain that her blood pressure was again high. Her relationship with her daughter and her husband were suddenly in a state of flux. Her daughter had decided to leave her house for permanent residence in Arizona, while her husband had begun talking openly about the possibility of divorce.

Each development was the culmination of progressively poor intra-familial relationships. She had had little control over her daughter's behavior since the latter's adolescence. Her daughter and grandchildren had moved out of Louisville a half dozen times in the previous ten years. Despite her daughter's indifference, she felt that she was contributing to the physical and emotional security of her grandchildren when they were near her. The daughter was the focus of her marital disagreements. Her husband continued his long-standing indulgence of their only child, who was, he felt, the innocent victim of an unfortunate environment, particularly an inadequately attentive mother. Each time her daughter left Louisville, her husband's anger toward her had increased. During the interims, indifference characterized their relationship, some of it calculated but most of it authentic.

At this time, the patient's blood pressure was 200/120 despite her continued use of medication. The guanethidine was gradually increased to 125 mgm each morning. During a five week period, she complained of continuous fatigue. She gained four pounds in weight because of overeating. Psychotherapy twice a week, sedatives, and tranquillizing drugs were used. On July 3, 1962, largely as the result of her instigation, her daughter left. Within a week, she remarked how greatly reduced her tensions were. Her old marital pattern returned. Once more, she could control her dietary intake. She gradually felt more relaxed, and, she became aware that her blood pressure was decreasing. A drop in her blood pressure to 130/85 with symptoms of orthostatic hypotension led to rapid reduction in the guanethidine to 25 mgm each morning.

On November 12, 1962, the patient was transferred to a particularly active department at work. She anticipated that the heavy work load would increase her emotional tensions as, she now realized, it had always done in the past. A program of adequate rest and variety of activity during her non-working day was discussed with her. During the six weeks of her heavy duty, the blood pressure was readily stabilized in the vicinity of 158/96 with 40 mgm of guanethidine each morning. On January 15, 1963, the guanethidine was no longer necessary. On one tablet Rautrax-N-Modified twice a day her blood pressure level stayed below 150/88. She was relaxed, and felt fine.

On March 12, 1963, she received a letter from her daughter stating that a move back to Louisville from Phoenix, Arizona was under consideration. Without hesitation, she wrote back a letter discouraging such a move because of the havoc it would create in established patterns of living, both for herself and her husband, as well as for her grandchildren. She told her daughter that she and her husband might visit her in Phoenix the following summer. Shortly thereafter her daughter decided to remain in Phoenix for awhile. During this period, the patient's blood pressure level, without drugs, remained at 146/87 and she felt well.

Discussion

An obvious objective of treatment for high blood pressure is to lower the blood pressure level. In some cases, this objective is clearly desirable. In patients with malignant hypertension, rapid lowering of the blood pressure definitely prolongs life. Removal of an aldosterone-producing adrenal tumor, or a pheochromocytoma, both potentially malignant, or surgical correction of a stenotic renal artery[1] not only may lower the blood pressure, but remove potential sources of disease in their own right.

In most patients in whom the existence of hypertension is unequivocal by reasonable criteria, however, the advantages of lowering the blood pressure are not at all apparent. The deadly complications of stroke and heart failure may be twenty or thirty years away and although the insurance companies feel their effect strongly, they may, at the time of treatment, be far from having the urgency of reality. Furthermore, not all studies agree that prolonged lowering of blood pressure by drugs is effective in lengthening life.[2, 3] Certainly this question cannot be answered without many years of intensive experimental study. Finally,

the patient may feel well at his high level of blood pressure and not desire, or respond unfavorably, to lowering of the level.

Lowering of blood pressure by the use of drugs is a complex problem. The casual blood pressure which ordinarily is taken in the doctor's office may not at all reflect the level during an intense argument or a sleepless night. In a given individual the response of the brachial blood pressure to stress under experimental conditions may be the same, regardless of the effect of antihypertensive medication upon the resting level.[4, 5]

The present case demonstrates that even a potent drug regime appears only to potentiate spontaneous drops in blood pressure. During one period a small amount of guanethidine caused orthostatic hypotension, while, a short time later, even larger doses had negligible hypotensive action. The arbitrary classification of elevated blood pressure into "labile" and "essential" categories overlooks the fact that spontaneous blood pressure swings in the latter group may be greater than in the former, even though at a higher average level.

Despite the many difficulties and limitations inherent in the treatment of idiopathic high blood pressure, logical reasons for its usefulness exist. A reasonable initial objective of blood pressure lowering in the asymptomatic patient with non-malignant, idiopathic hypertension is the opportunity for the patient to re-experience the sensations associated with a lower blood pressure level.

Frequently, with the onset of the pressure drop, unpleasant feelings of weakness or lack of energy may occur, and the rate of pressure reduction may have to be slowed. When, with encouragement, he has become accustomed to, and even learned to enjoy, the new sensations, a major step has been taken in his rehabilitation. He may only then realize how tense, unhappy, and unproductive had been the period of his highest blood pressure, when he may have felt himself most free and productive. Only when this insight has developed has the treatment left its initial phase. From then on, the patient becomes aware of blood pressure elevation by correlation of the abnormal sensations it produces in him with measured levels of blood pressure and realizes, with psychotherapeutic assistance from the internist, the relationship of the elevation to the situations which produce it.

The abnormal feed-back mechanisms which maintain a high average pressure level are not at all resistant to voluntary action. By direct modification of his environment or control of his relationship or reaction to it, the patient learns to avoid or minimize tension producing situations. The lowering of blood pressure reflects the development of increased emotional control.

Summary

A reasonable initial objective of blood pressure lowering by the use of drugs is the opportunity for the patient to re-experience the sensations associated with a lower blood pressure level. With psychotherapeutic assistance, he then learns to become sensitive to blood pressure elevation, to use his reaction as a gauge for the tension-producing qualities of his life situations, and to modify or react to them in a tension-reducing way.

References

1. Pickering, G.W.: *High Blood Pressure,* New York, N.Y.: Grune & Stratton, 1955.

2. Page, I. H.: The Changing Outlook for the Hypertensive Patient, *Ann of Int Med 57:* 96-109 (July) 1962.

3. Perera, G. A.: Antihypertensive Drug versus Symptomatic Treatment in Primary Hypertension, *J Am Med Assn 173:* 11-13 (May) 1960.

4. Shapiro, A. P.: An Experimental Study of Comparative Responses of Blood Pressure to Different Noxious Stimuli, *J Chron Dis 13* 293-311 (April) 1961.

5. Shapiro, A. P.: Pressure Responses to Noxious Stimuli in Hypertensive Patients. Effects of Reserpine and Chlorothiazide, *Circulation 26:* 242-250 (Aug) 1962.

CASE DISCUSSIONS
From The
University of Kentucky Hospitals

U. K. Medical Center Hospital

Pregnancy Complicated By Congenital Spherocytic Hemolytic Anemia And Cystic Teratoma of Ovary

J. W. Greene, Jr., M.D.,* Madison Cawein, M.D.,** E. J. Lappat, M.D.***

MRS. R. D., a 19-year-old white gravida 1 para 0, was referred to the University of Kentucky Medical Center on May 9, 1963 for removal of a pelvic tumor complicating pregnancy. The last menstrual period occurred October 14, 1962 giving an expected date of confinement of July 21, 1963. Although these are the dates reported by her there was some question about the last menstrual period since it was not entirely normal, being shorter in duration and the uterine size was four weeks larger than one would expect.

Physical examination revealed mild scleralicterus. The spleen was palpable two fingers below the left costal margin. The uterus was palpable 4 cm above the umbilicus and was symetrical. Fetal heart tones could easily be heard. Pelvic examination revealed a mass 8 to 9 centimeters in diameter in the cul-de-sac displacing the cervix anteriorly under the symphysis, making it very difficult to visualize, although when visualized it was found to be well epithelized, blue, and without erosion. The pelvic mass was tense, cystic and obstructing the pelvic outlet.

Laboratory studies showed a hemoglobin of 12.0 gm %, a hematocrit of 31%, and a red blood cell count of 3.5 million with a reticulocyte count of 17%. The blood smear showed spherocytosis, polychromasia, and basophilic stippling. The serum bilirubin was elevated with the preponderance of elevation in the unconjugated fraction. Osmotic fragility studies showed an increase in fragility with a shift to the left of the curve after incubation for 24 hours. A Heinz body preparation was positive. A Coombs' test was negative. No deficiency in glucose-6-PO-4 dehydrogenase was demonstrated. Urine analysis was normal. Gall bladder x-ray showed the presence of multiple radiolucent stones in the gall bladder. Study of the patient's mother and sister revealed a similar spherocytosis and fragility curves similar to that found in the patient's blood. These findings are compatible with hereditary spherocytic hemolytic anemia.

Past Medical History

The patient, her mother, and her sister have been known to have a congenital spherocytosis. At the age of nine in association with a respiratory infection, she had become severely anemic. A bone marrow examination then showed a maturation arrest of erythropoiesis with the presence of the large erythrogenes of Ovren. A maternal first cousin and a maternal uncle was also known to have congenital spherocytic hemolytic anemia.

Because of the position and size of this pelvic tumor removal was imperative. Preoperatively 125 mg of 17 alpha hydroxy progesterone caproate was given. On May 21, 1963 under general anesthesia a right paramedium incision was made and the peritoneal cavity entered. With gentle palpation behind the uterus a cyst was delivered from the cul-de-sac arising from the right ovary. This right ovary was replaced by a 12 x 7 centimeters smoothed walled tumor typical of a cystic teratoma. Because of the size and tremendous vascularity about the ovary a right salpino ovariectomy was carried out. Upon opening this cyst after excision, pultaceous material and hair characteristic of a cystic teratoma was found. The gall bladder area was palpated and multiple small stones were found. The spleen was enlarged two times normal size.

The patient did very well following the operation with the exception of uterine contractions that abated after sedation and the administration of isoxsuprine 10 mg. intra-muscularly. Two days following the operation the patient was noted to have increased jaundice and her bilirubin reached the levels of 7.4 mgs% total with 3.5 mgs.% conjugated. Since there was no abdominal pain or fever it was felt that the patient was undergoing a hemolytic crisis rather than biliary tract obstruction. No definitive therapy was given except all medications that the patient had been receiving were stopped which included dextropropoxphene, demerol, and a barbiturate. She was discharged from the hospital on May 30, 1963 with a hemoglobin of 9.0 gms% and a hematocrit of 23%.

*Professor and chairman of the department of Obstetrics and Gynecology at the University of Kentucky College of Medicine.
**Chief, section of Hematology, University of Kentucky College of Medicine.
***Professor, department of Medicine, University of Kentucky College of Medicine.

The abdominal wound was well healed and the pregnancy progressing normally.

The next hospital admission was on June 17, 1963 at which time she was in active labor; the cervix 8 cm dilated, 100% effaced, the head at station +2. She was delivered of a viable female infant weighing 2 pounds 2 ounces without complications. In the post partum period episodes of hemolysis with a total billirubin level of 4.5 mgs % with 0.9 mgs % of conjugated bilirubin were found. Except for this her post partum period was uneventful and she was discharged from the hospital on June 21, 1963.

Discussion

Hematologic findings were compatible with hereditary spherocytic hemolytic anemia. Following surgery and delivery the patient developed increasing jaundice, a rise in the unconjugated fraction of serum bilirubin, a fall in hemoglobin, and an elevation in the reticulocyte count. It was felt that this represented an acute hemolytic episode. This episode developed in conjunction with the administration of dextro-propoxphene hydrochloride (Darvon®). This molecule appears to be of a type which could cause hemolysis in a sensitive cell. This impression was further strengthened by the presence of Heinz bodies and by the fact that the acute hemolysis subsided following discontinunce of the drug. However, it should be emphasized that this drug cannot be definitely incriminated since the patient was on other drugs at the same time. In vitro studies are planned to determine whether or not this drug does have the potential of causing hemolysis in various types of erythrocytes. This patient demonstrated the fact that caution should be used in administration of drugs of any type to patients with hemolytic anemia.

The incidence of ovarian neoplasma in pregnancy is reported to vary from 1 to 80 to 1 to 1000.[1] The most common tumor found in the reproductive age is a cystic teratoma. Ovarian tumors can be divided into two large classifications: the non-proliferative and the proliferative. In the former, enlargements are non-neoplastic and include: corpus luteum cysts, follicular, tubo-ovarian, and theca luteum cysts. Although these do not become malignant they are subject to the accidents that can occur with any ovarian tumor. The proliferative tumors can be divided into epithelial, embryonic, connective tissue, and those of malignant or metastatic origin. The hazards of these ovarian enlargements during pregnancy include: the malignant potential, rupture, hemorrhage, and twisting with the subsequent necrosis.

Ovarian tumors are best diagnosed in early pregnancy when the enlarged uterus does not interfere with pelvic examination. The discovery of a small freely movable cyst with no areas of firmness might indicate expectant management providing it was no larger than six centimeters in diameter. Tumors larger than six centimeters in diameter, particularly if there is any suggestion of it being a solid tumor, should be removed immediately.

The time of removal of ovarian tumors complicating pregnancy has been the subject of considerable controversy. In the presence of such acute accidents as torsion with subsequent necrosis, hemorrhage, or suspected malignancy, certainly operation is immediately indicated. If immediate operation is not indicated, surgery should be deferred until the middle trimester of pregnancy. At this time great care has to be taken in order not to disturb the uterus and to obtain complete hemostasis. If removal is done during the second trimester, the removal of the corpus luteum does not seem to increase the incidence of fetal loss. There are series of cases in the literature in which the corpus luteum has been removed as early as the third week of gestation without fetal loss.[2] Practically all these cases have had supplemental hormonal therapy. Occasionally the presence of an ovarian tumor is not recognized until the patient is examined just prior to or during labor, and the birth canal is found to be obstructed by the mass. It has been recommended that general effort should be made to displace the mass upward and allow the fetal head to come into the pelvis.[1] Aspiration has been described, but because of the possibility of infection, or malignancy, this should not be undertaken. If it is impossible to displace the tumor as it was in the above case, the patient should be treated by immediate removal with thought given to attempting to deliver the patient vaginally. In our case it was fortunate that the tumor was discovered at such a stage of gestation so that the tumor could be removed without disturbing the pregnancy and to allow a subsequent normal vaginal delivery.

References

1. Journey, R. W., and Payne, F. L., *Nonobstetric Surgical Complications During Obstetric Care*: A Review of the Recent Literature. American Journal Medical Sciences *232*:, 695, 1956.
2. Hall, R. E. *Removal of the Corpus Luteum in Early Pregnancy:* Review of the Literature and Report of Two Cases. Bull Sloane Hospital for Women. 1:49, 1956.

SPECIAL ARTICLES

Warren County's Questions on Kerr-Mills Answered

Editor's Note: Since one of the purposes of The Journal is to serve as a forum for the members of KSMA, it was felt that the following letter and its reply should be published as requested. However, the opinions herein expressed are not to be construed as those of The Journal or its editors, but of the individuals and/or groups to whom authorship is credited. S.A.O.

DEAR Doctor Overstreet:

Whenever and wherever the occasion permitted in the past three years, the Warren County Medical Society has sent its spokesmen to debate the merits of the Kerr-Mills program as implemented in this Commonwealth. *The Journal of the Kentucky State Medical Association* issue of February, 1964, contained a resume of the program's first three years. The article ended with the question (possibly rhetorical) "Is it too much to ask all of our membership to fully support this plan?". If we may once more into the breach, yes, it is.

Members of the Warren County Medical Society have been warned repeatedly that resistance to this program invites a compulsory medical care program invites a compulsory medical care program in the Social Security Act. We find it hard to believe that so frail a jawbone as the Kerr-Mills program will long rebuff the Philistines of socialism. Still, in a spirit of cooperation, we have supported the program by prescribing its medications, signing its nursing home examinations and monthly reports, and completing our hospital admission sheets in the regulation reproducible black ink—all without recompense. We maintain, therefore, that we are fully supporting three-fourths of the portion of the program with which physicians are concerned. The other fourth is acceptance of fees paid to physicians for their services to approved indigents. Our refusal to cooperate here is for reasons of both philosophy and politics and we are as adamant in our stand now as we were in January, 1961. We believe that our caring for medial indigents without fee is a powerful weapon in our fight against government medicine. In fact, we regard this practice, rather than the Kerr-Mills program, as the principal weapon we have. It is one we will not surrender.

The Kerr-Mills program, as administered in Kentucky, has many admirable features. The administrative personnel we have met are well-informed, well-motivated, and cooperative. The screening of applicants in our area has been scrupulous but sympathetic. Ancillary medical services have seriously endeavored to make the program a success.

A few aspects of the program are execrable. The existance of a drug list, masquerading as a control on costs, is a direct infringement of the free practice of medicine. The members of this Society challenge the administrators of the program to allow free prescription of all usual and reasonable drugs in usual and reasonable quantities on a month-to-month basis. Since we feel this program to be valuable to our profession, we will surely not weaken it financially by extravagant prescriptions. Corollary benefits are that recipients will obtain all their medications through the program intead of only a part of them and the elimination of detailed prescription monitoring should effect some reduction in administrative costs. Furthermore, the tendency to prescribe quantities allowed on the drug list will be eliminated. The cost of the program's drugs could well decrease. Relative freedom in drug prescriptions will also obviate the possibility that at some future time the choice of drugs for use in the program may not be dictated altruistically.

We do not know of any other government agency, organization, or program which requires the use of a special prescription blank except the Kerr-Mills program in Kentucky. Our professional prescription on our blanks are honored by the Armed Forces, the G.S.A., the Veterans Administration, Workmen's Compensation Boards, and, so far as we know, the Sick Bay of ships at sea. Isn't it time that our professional prescriptions are divorced from bookkeeping entries?

Finally, have any serious studies been concluded regarding the relative advantages of administering the program under the auspices of Blue Cross-Blue Shield? Their record of achievement in the field of medical financing is unassailable—that of government agencies is at least still open to question

In summary, the members of the Warren County Medical Society reiterate that we do not oppose the aims of the Kerr-Mills Act, but only a portion of the program as administered in the Comonweath of Kentucky. We have accepted and are using every benefit of the plan that we can.

Is it to much to ask our leaders to consider modifications to enable us to fully support this plan?

Very truly yours,
Martin Wilson, M.D., Legislative Key Man
THE WARREN COUNTY MEDICAL SOCIETY

Another Viewpoint

The question of providing medical care to those of our elderly citizens in this country who are unable to provide it for themselves, is a most controversial one. There are few subjects currently discussed in our various professional groups, by prospective recipients of such services, by taxpayers, and by many members of the U.S. Congress, which have produced more heat and less light. Basically the conflict resolves itself into the question of whether a Social Security-based program or one financed from the general funds by direct appropriations (an example of the latter is the present Kerr-Mills Program) would be more desirable.

It seems at this time that most of those who have considered this problem in detail including the professions, employers of large groups, and legislators, especially members of the House Ways and Means Committee, feel that the Kerr-Mills type program is more desirable, for several reasons, some of which are:

1) The plan is voluntary as relates to both Vendor and Vendee—hence more democratic.

2) It only provides services, at the taxpayer expense, to those who are in need.

3) There is a degree of local control of the program and it can be reduced in scope as usage decreases. A plan once established in the Social Security program would never be terminated. The Social Security Tax is already scheduled to take 9 + % of the payroll by 1969 without medical care. This figure approaches the arbitrary 10% which has been considered by many as the maximum level this tax can reach without becoming an impediment to industry.

For these reasons and others, the Congress in 1960 declined to approve a Social Security based medical care program, but instead established the MAA or Kerr-Mills plan.

The AMA feels that since professional people are taxpayers and since no other group of vendors provide services and commodities to indigents totally gratus, we should not be the exceptions, although they be token fees as they are in the Kentucky MAA plan. Even if the current generation of physicians wish to provide services gratis, is it logical for us to commit future professional generations in this manner? After a State plan is established, it is very difficult to secure changes requiring resources from many legislative groups. The California Medical Care program had an unlimited drug list until 1960 when it found itself practically bankrupt, since which time there have been restrictions. Not every physician and every patient would abuse the privilege of an unlimited drug list, but the experience of other and older plans than that of Kentucky have found this tendency, and many protect themselves as we have done.

The special prescription forms are required by the Department of Economic Security, and an effort has been and is still being made to simplify the requisition forms. Blue Cross and Blue Shield in Kentucky have been approached in respect to administering the Kerr-Mills program, but to date they have not felt that it would be practical, especially home and office calls, which are not included in their program. This effort will be continued.

In Kentucky there are over 2,000 individual physicians who are required by occupation to make many decisions, daily, on which we can stand and defend ourselves, and this is as it should be—but, by the same token, it contributes to the formation of a diversity of opinions on any subject, including the Kerr-Mills Plan. This characteristic applies also to the other vendor members who provide medical services in its broad sense to our elderly indigents—and also to the two state departments who administer and direct the programs on a state level. In addition there are several restrictions on a federal level related to use of public funds. When this matter is soberly considered it becomes obvious that it is not easy to plan and procure a mechanism which is approved by everyone concerned. It is only natural that there be individual criticisms, many of which are valid and no doubt constructive.

The PA and MAA plans for medical care in Kentucky are of relatively recent vintage and should be modified in light of experience to provide a maximal benefit to those actually in need, and to no others, at a minimal cost to the taxpayer, and a minimal disturbance from an administrative standpoint to the vendor of services.

The KSMA Technical Advisory Committee to the MAA Plan in Kentucky is very ably directed, and all suggestions of ways and means of improving the program in any way as relates to physician services, should be directed to the chairman of this group.

Gaithel L. Simpson, M.D.
Chairman, Governor's Advisory
Council on Indigent Medical Care

EDITORIALS

Credit To Whom It Is Due

IN this issue of the Journal will be found comments relative to the first graduating class at the University of Kentucky College of Medicine. This is an event deserving of publicity; the Medical Center at Lexington is a magnificent complex of which every Kentuckian may justly be proud. We present herewith him who in our opinion is the father of this fine institution, John S. Chambers, M.D., F.A.C.P., of Lexington.



Doctor Chambers

Doctor Chambers came to the University of Kentucky in 1928 as the Director of Health Services and remained in that capacity until his retirement in 1957. It was soon after he assumed this position that he began to study the needs of medical education in Kentucky. From year to year he compiled information and statistics and firmly established the need for an additional medical school in our State. His numerous surveys comprise a volume of information which was never widely publicized but was presented from time to time to the presidents and Board of Trustees of the University. When early in the decade of 1950 interest was awakened to the need for increased opportunities for medical education in Kentucky Doctor Chambers came forward with the material he had accumulated which established beyond any question the urgent need of not only a school of medicine but a school for dentistry and the allied medical sciences at the University of Kentucky.

In 1957 he became president of the Kentucky Medical Foundation. His insistance was upon superior quality for the new medical school and its standards of teaching. He undertook to seek endowment funds to enrich the school beyond what is possible by State appropriations only. If this quest has not succeeded it is not due to lack of vision or effort on his part.

Doctor Chambers' portrait should hang in the library of the medical School to remind future generations of physicians who will study there that he contributed very materially to their development and to the advancement of better medical care in Kentucky.

In 1953 the Kentucky Medical Foundation was organized, consisting of fifty professional and business men and women evenly distributed over the State. The purpose of this foundation was to publicize the need for better medical education in the State and to influence legislation toward the establishment of a new school. In the five years that followed this group created an atomosphere throughout the State and in the legislature favorable to the development of medical center at Lexington, and actually made its accomplishment possible.

Mr. J. Stephen Watkins accepted the presidency of the Kentucky Medical Foundation. It was very largely by his personal knowledge, drive, and magnetism that the objectives of this organization were so well accomplished. Without a leader of his caliber and of his dedication to the ideal of improved medical care in Kentucky it is doubtful whether the Medical Foundation would have achieved its objective.

When it was announced in the daily press that the Governor had withdrawn $500,000.00 annual state aid to the University of Louisville School of Medicine, it was upon the insistence of Dean Kinsman, together with Doctor Chambers and others of the Kentucky Medical Foundation that the Governor was influenced to reinstate the appropriation. This reversal of decision was accomplished within a few days and state aid to the Louisville School has continued and increased annually since that time. Had not Mr. Watkins had an impartial attitude toward betterment of medical education throughout the State the University of Louisville would

have suffered an almost insurmountable financial crisis during the past six years.

William R. Willard, M.D., F.A.C.P., then dean of the University of Syracuse School of Medicine, visited Lexington and accepted the challenge and responsibility of deanship of the proposed medical school. He came when the present medical center site was but an open field. He was the principal planner for the development of the medical and dental schools and the entire Medical Center. He traveled widely over the United States to inform himself of the best developments in construction in order that this new institution might serve its purpose in the most effective means possible.

He accumulated material concerning the best methods in medical teaching. He established a curriculum somewhat different from the conventional ones of the past century. The first four years operation of the school has apparently established the excellence of his judgements.

He recruited a faculty which is the pride of our State and the envy of the older medical colleges. He quickly adapted himself to his new surroundings, made himself available to every medical body or institution in the State for advice and counsel. He graciously accepted and used the suggestions of those acquainted with medical problems in Kentucky and has incorporated these, along with his own progressive schemes, into the health program of the Medical Center to better serve the entire State.

To these three men—a business leader and two distinguished physicians—the medical profession and the entire state of Kentucky owe a debt of gratitude. They have set a high standard for improved medical care throughout the State. We would be remiss to deny them the honor and credit they so much deserve.

SAM A. OVERSTREET, M.D.

A Problem of Communications*

TWO areas in which medicine today experiences much difficulty are our relations as a profession with the general public, and an ill-defined difference between our academic and clinical worlds. Both would seem to have a common origin, a lack of communication.

Regarding the former, the conduct of medicine is wisely governed by Hippocratic ethics. This infers conscientious care of the sick, respect of confidence and reluctance to publicly criticize. In no way should these principles be subverted either by our actions or by governmental decree.

If this reasoning were understood and what has been accomplished within this philosophy recognized, our problems today would be somewhat less. Regrettably, by apathy or default, we are now on the defensive.

Therefore we, as a profession, must convey our thoughts through our Societies and, more importantly, individually to others. This can only be done by a wholesome doctor-patient relationship and by active participation in community responsibility. We must assist in the formulation of plans for the public good and not merely assume a role of negation.

Regarding the second point, the evolution of medicine today has led to a relative isolation of those primarily interested in teaching from the practitioner. There are reasons for this but, since fundamentally the objectives are the same, this situation in its turbulent extremes is ridiculous. Here again the insular or laissez-faire attitude has on occasion given rise to maliginant misunderstanding. This may be averted by a candid exchange of ideas either on a personal basis or by the utilization of a persistant active liaison committee.

To summarize: The two major problems which face our profession at the moment arise from lack of communication within our own ranks and with others outside. We can and must by persistent individual effort right what has gone wrong and allay the difficulties of the future for the good of all.

I leave you with a thought from Thomas Jefferson: "Error of Opinion may be tolerated where reason is left free to combat it."

Andrew M. Moore, M.D.

**The edited version of an address delivered by Andrew M. Moore, M.D., on the occasion of his inauguration as president of the Fayette County Medical Society, March 10, 1964.*

ORGANIZATION SECTION



"I Swear by Apollo Physician" — The Class of 1964 of the University of Kentucky College of Medicine Swears to abide by the Oath of Hippocrates, administered by William R. Willard, M.D., dean of the College during May 18 ceremonies at U.K. Thirty-one men and one woman took the oath to become the College of Medicine's first graduating class. See Photo, page 458.

First Commencement at U. K. College of Medicine Signifies Realization of Plans and Effort

The years of effort spent in the planning, organizing, and construction of the University of Kentucky College of Medicine culminated May 18 in the graduation of the first medical class at U.K.'s Memorial Coliseum.

The oath of Hippocrates was administered to 32 graduates in special ceremonies that afternoon at Memorial Hall by William R. Willard, M.D., dean of the College of Medicine, while a score of dignitaries, including Kentucky Governor Edward T. Breathitt and former Governor A. B. Chandler, looked on. Calvin H. Plimpton, physician and president of Amherst College, Amherst, Mass., addressing the graduating class, urged them to seek individuality.

Among those recognized at the ceremony were KSMA president George P. Archer, M.D., Donn L. Smith, M.D., dean of the University of Louisville School of Medicine, and Andrew M. Moore, M.D., president of the Fayette County Medical Society. ,

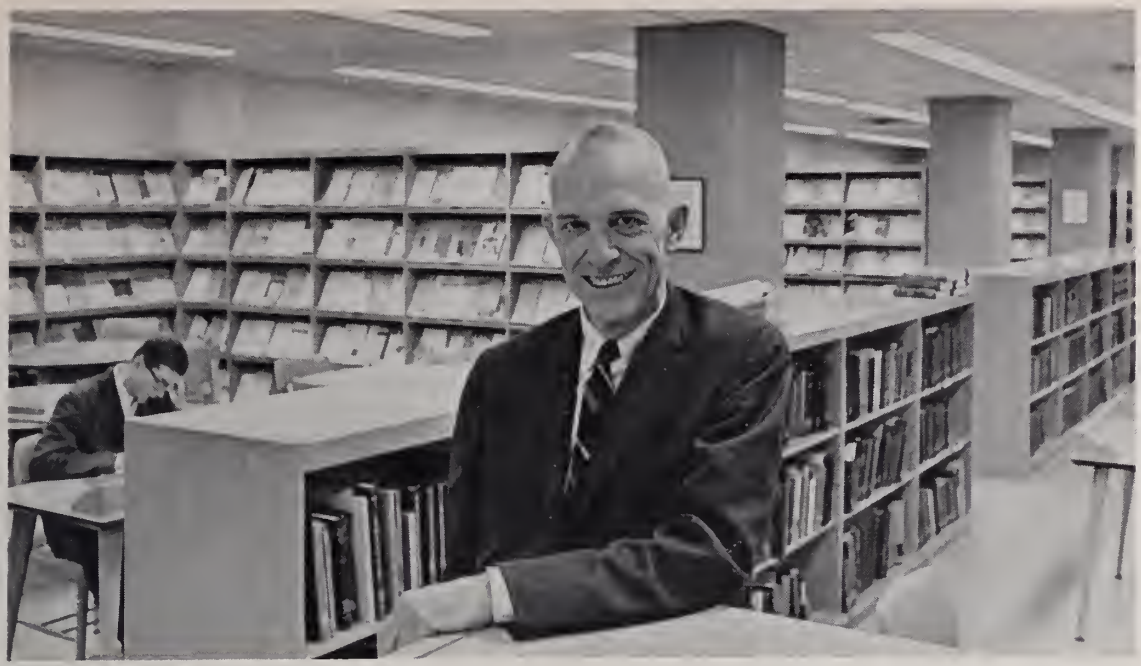
Doctor Willard, who is also vice-president of the Medical Center, introduced Governor Breathitt, chairman of the University Board of Trustees, and Doctor John W. Oswald, president of the University. Both paid tribute to former Governor Chandler, in whose honor the Medical Center is named, for the contributions he has made to the Center.

Charles B. Wilson, M.D., of U.K.'s department of surgery, was honored as the first recipient of the Outstanding Clinical Instructor Award from the graduating class, which is to become an annual presentation during commencement exercises.

Graduation Marks Medical Milestone

The graduates of the College of Medicine represent 17 Kentucky counties, seven other states, and one foreign country. Seven of the group possess advanced degrees—four Masters' degrees and three Ph.D.'s. Of this number, whose ages range from 23 to 37, 20 are married and 15 are parents.

Though their vital statistics may be approximated in any medical school in the country, the U.K. College of Medicine's Class of 1964 represents a milestone in the history of medicine in Kentucky. Their graduation marks the realization of a dream more



William R. Willard, M.D., dean of the University of Kentucky College of Medicine, and vice-president of the Medical Center, poses in the College's medical library. The impressive library, a point of pride of the Medical Center, now contains some 80,000 volumes. Doctor Willard said that eventually he hopes to have 110,000 volumes in the library.

than 35 years old, when, in 1928, the late Frank L. McVey, then president of the University, asked J. S. Chambers, M.D., head of the department of Hygiene and Public Health at U.K., to make a study of the medical needs of the state with a view toward establishing a new medical school.

Doctor Chambers, also honored at the graduation ceremony, accumulated the data and presented it to the Board of Trustees, with the result that, on June 1, 1954, the Board acted to create the University of Kentucky College of Medicine. Doctor Chambers retired in 1960.

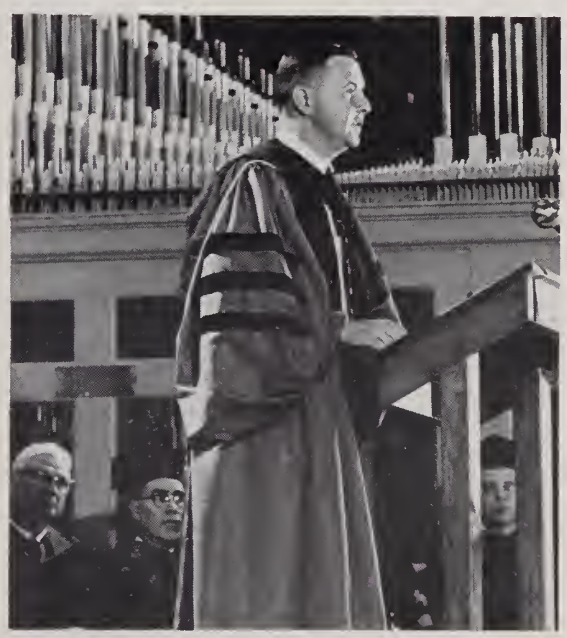
Center Dedicated in 1960

In 1956 the Kentucky General Assembly made an initial appropriation of $5,000,000. That same year, in July, announcement was made of the appointment of William R. Willard, M.D., then dean of the Upstate Medical Center of the State University of New York at Syracuse, as vice-president of the new Medical Center and Dean of the College of Medicine.

Under the direction of Doctor Willard, plans were then drawn up, construction began, and the first faculty members chosen. The first unit of the huge facility, the Medical Science Building, was completed in 1960 and dedicated in September of that year—the same year the first medical class was accepted from more than 400 applications.

The 27,000,000 Medical Center now stands complete, with the Medical Science, Dental Science, and Teaching Hospital buildings, on 39 acres of what was a part of the University's Agriculture Extension Farm.

The efforts of Doctors Willard and Chambers, and of many other Kentucky citizens, have finally been realized. The Class of 1964 will stand as a symbol of a turning point in medical education in Kentucky.



Calvin H. Plimpton, M.D., president of Amherst College, Amherst, Mass., addressed the first graduating class of the University of Kentucky College of Medicine in special ceremonies May 18 at Memorial Hall on the University Campus. On the platform with Doctor Plimpton are, from left, Thomas F. Whayne, M.D., vice-president of the Medical Center; George P. Archer, M.D., KSMA president; and Andrew M. Moore, M.D., president of the Fayette County Medical Society.

Members of the Class of 1964
The First Graduates of

The University of Kentucky College of Medicine





Young Woman
Reading a Letter

JOHANNES VERMEER
1632-1675

In Pregnancy...

METAMUCIL® Acts Gently, Safely, Effectively

brand of psyllium hydrophilic mucilloid

The highly refined mucilloid of Metamucil corrects constipation in pregnant patients simply by augmenting the natural stimulus to peristalsis.

The bland, smooth bulk provided by Metamucil softens hard fecal masses, stimulates natural reflex activity of the intestinal musculature without irritant or systemic effects and tends to restore the normal rhythms of elimination.

Average Adult Dosage: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid. Metamucil powder contains equal amounts of refined, purified psyllium and dextrose furnishing 14 calories and is available in containers of 4, 8 and 16 ounces.

Instant Mix Metamucil is supplied as individual single-dose packets, each incorporating 0.25 Gm. of sodium, in cartons of 16 and 30.

G. D. SEARLE & CO.
CHICAGO, ILLINOIS, 60680
Research in the Service of Medicine



Doctor Szilagyi



Doctor Carrington

Top-Ranking Guest Speakers Feature of Annual Meeting

Fourteen carefully-selected guest speakers, representing as many cooperating specialty groups, will participate in an outstanding scientific program during the Kentucky State Medical Association's Annual Meeting at the Convenion Center in Louisville Sept. 29-October 1.

George P. Archer, M.D., KSMA president and chairman of the Council on Scientific Assembly, in urging the attendence of all KSMA members, said, "This year's scientific program promises to be one of the most informative ever presented by KSMA. Carefully gathered material will be presented by authoritative speakers on subjects which will benefit every physician in the state."

Doctor Archer released information about two of the guest speakers who will address the general scientific sessions at the Annual Meeting. Additional biographical material on other speakers will appear in subsequent issues of *The Journal.*

On Diabetes Symposium

D. Emerick Szilagyi, M.D., who will be the guest of the Kentucky Chapter of the American College of Surgeons, will address the general scientific session on Thursday morning, October 1. He will also participate in a Thursday morning Diabetes Symposium panel discussion made possible by a grant from the Merck Sharp and Dohme Postgraduate Program. He will speak before his host specialty group that same afternoon.

A 1935 graduate of the University of Michigan School of Medicine, Doctor Szilagyi is a native of Hungary. He is currently surgeon-in-charge of the division of General Surgery at Henry Ford Hospital, Detroit. Among his professional affiliations are membership in the American College of surgeons, the International Society of Surgery, the American Federation for Clinical Research, the International Cardiovascular Society, and the American Surgical Association.

Elsie Reid Carrington, M.D., research professor of Obstetrics and Gynecology at Women's Medical College of Pennsylvania at Philadelphia, will be the guest at the Annual Meeting of the Kentucky Obstetrical and Gynecologic Society. Doctor Carrington, who will also take part in the Diabetes Symposium on Thursday morning, will speak on "Endotoxic Shock in the Obstetric Patient" before the general scientific session on Wednesday morning. She will also address her host specialty group that afternoon.

Doctor Carrington, who is a 1941 graduate of Temple University School of Medicine and received postgraduate training there, is a former member of the Temple faculty.

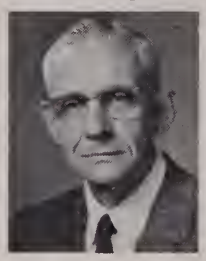
Two Kentucky M.D.s to Take Part In AMA Scientific Program

Edmund D. Pellegrino, M.D., professor and chairman of the department of Medicine at the University of Kentucky Medical Center, will participate in a panel descussion on "Joint Planning of Patient Care by Physicians and Nurses in the Hospital and Home," on June 24 during the scientific program of the American Medical Association's annual meeting to be held in San Francisco June 21-25. The discussion will be sponsored by the AMA Committee on Nursing.

Thomas R. Marshall, M.D., associate professor of radiology at the University of Louisville School of Medicine, will present a paper on "Percutaneous Non-Catheter Brachial Angiography" on Thursday, June 25 as a part of the two-day special scientific session covering cardiovascular disease.

Dr. Scott to Head SE Section Of American Urologists

Douglas E. Scott, M.D., Lexington, was named president-elect of the Southeastern Section of the American Urological Association at its recent meeting in Bellaire, Florida.



Doctor Scott, who is currently serving as chairman of the KSMA Board of Trustees, and is a past president of the Fayette County Medical Society, has been treasurer of the Urological group for the past two years.

Doctor Scott will be inducted as president at the 1965 meeting of the section in Miami and will complete his term of office in 1966 when the group meets at Memphis. Approximately 500 physicians and their wives attended the Bellaire meeting.

Louisvillians Named to ACP

Stuart Graves, M.D., and Charles C. Smith, M.D., both of Louisville, have been named associates of the American College of Physicians, according to an announcement by Thomas M. Durant, M.D., Philadelphia, president of the ACP.



WHY DOES ONE ANTIBIOTIC GIVE UP TO 2 EXTRA DAYS' ACTIVITY?

Because it is more resistant to disintegration, has a lower renal clearance rate than earlier tetracyclines[1]...a favorable depot effect resulting from protein binding and greater mg. potency...all giving higher, sustained *in vivo* activity which continues long after the last dose.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections — respiratory, urinary tract and others — in the young and aged — the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.
Side Effects typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules*, 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Kunin, C. M.; Dornbush, A. C., and Finland, M.: Distribution and Excretion of Four Tetracycline Analogues in Normal Young Men. *J. Clin. Invest.* 38:1950 (Nov.) 1959.

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
7517-3

Lederle

KSMA Trustee Districts Hold May Meetings

Six trustee districts have held meetings during May as the deadline for this issue of The Journal is met.

Attendance, according to George P. Archer, M.D., KSMA president, who has attended and spoken at each meeting, has ranged from average to excellent. The May meetings included:

May 5th, Eleventh District, Hubert C. Jones, M.D., Trustee; meeting at Richmond.

May 12th, Sixth District, Rex E. Hayes, M.D., Trustee; meeting at Russellville.

May 13th, Joint meeting of the Twelfth and Fifteenth Districts, Thomas O. Meredith, M.D., (Twelfth) and Robert C. Pennington, M.D., (Fifteenth) Trustees. Warren E. Wheeler, M.D., Lexington, and William P. Peak, M.D., Louisville, presented a scientific program at the meeting at Somerset.

May 14th, Fourth District, Dixie E. Snider, M.D., Trustee; meeting at Bardstown. Benjamin B. Jackson, M.D., Louisville, presented the scientific program.

May 21, Seventh District, Donald Chatham, M.D., Trustee; meeting at Shelbyville. Dean Donn L. Smith of the U. of L. School of Medicine shared the program with Doctor Archer.

As we go to press, meetings are scheduled to be held for the following districts:

Second District, Howell J. Davis, M.D., Trustee; meeting May 26 at Owensboro.

First District, O. Leon Higdon, M.D., Trustee; meeting May 27 at Paducah.

Third District, Gabe A. Payne, Jr., M.D., Trustee; meeting May 28 at Hopkinsville.

Ninth District, Mitchel B. Denham, M.D., Trustee; meeting June 3 at Paris.

Eighth District, W. Donald Janney, M.D., Trustee; meeting June 4 at Covington.



Delmas M. Clardy, M.D., Hopkinsville, KSMA president-elect and Kentucky Blue Shield Board Member, second from left, discusses a Blue Shield matter during a break in the Interim Meeting with Daniel F. Hanley, M.D., left, a guest speaker at the meeting and a member of the Maine Blue Shield Board of Directors, D. Lane Tynes, executive director of the Kentucky Blue Cross-Blue Shield Plans, and Wyatt Norvell, M.D., New Castle, senior delegate from the KSMA to the AMA and Blue Shield Board members.



Sitting at the speakers' table at the opening ceremonies of the KSMA Interim meeting were, bottom row, from left, Douglas E. Scott, M.D., chairman of the KSMA Board of Trustees, Reverend W.D. Jaggers, Prestonsburg, who delivered the invocation, and George P. Archer, M.D., KSMA president. Standing are Delmas M. Clardy, M.D., KSMA president-elect, Douglas Adams, M.D., Floyd County Medical Society president; and Henry B. Asman, M.D., KSMA secretary. Keith P. Smith, M.D., Corbin, treasurer, and Gabe A. Payne, M.D., Hopkinsville, vice-chairman of the Board, were unable to be present for this photograph.

1964 KSMA Interim Meeting Sets Attendance Record

The largest attended KSMA Interim Meeting (215) in KSMA history was held April 23 at Jenny Wiley State Park, Prestonsburg, when outstanding presentations focusing on "64—Medicine's Year for Political Action", were well received by those present.

Kentucky physicians, their wives and guests, heard Daniel F. Hanley, M.D., executive director of the Maine Blue Cross-Blue Shield Plans, discuss the close alliance between the well-being of voluntary health care and that of medicine.

Ernest B. Howard, M.D., Chicago, assistant executive vice-president of the American Medical Association, stated to the group that the main issue in the current struggle is the question of the responsibility of financing health care for the non-needy.

Congressman Durward G. Hall, M.D., Springfield, Mo., challenged physicians to remain on the alert, reminding his listeners that even if the King-Anderson Bill is not allowed out of the House Ways and Means Committee, it may still appear on the floor for a vote as an amendment to some other bill.

The final speaker of the day-long program, Doctor Nicholas Nyaradi, director of the School of International Studies at Bradley University. A former Hungarian Finance Minister, Doctor Nyaradi, an expert on the Soviet Union and on Communist policies in his own native land, contrasted free-enterprise and Communistic systems.



KSMA President George P. Archer, M.D., second from right, takes advantage of a break in the Interim Meeting sessions to chat with guest speakers Daniel F. Hanley, M.D., Brunswick, Me., left; Ernest B. Howard, M. D. Chicago, and, at right, Durward G. Hall, M.D., a Congressman from Springfield, Mo.



George P. Archer, M.D., right, KSMA president, presents checks from the American Medical Association's Education and Research Foundation (AMA-ERF) to the deans of Kentucky's two medical schools during the KSMA Interim Meeting at Jenny Wiley State Park. William R. Willard, M.D., left, dean of the University of Kentucky College of Medicine, accepts a check for $5,279.28 from Doctor Archer. U. of L. Dean Donn L. Smith, M.D., right, received $10,369.36 for his school.

Dr. Conner New KSMA Historian

Eugene H. Conner, M.D., professor and chairman of the department of anesthesiology at the University of Louisville School of Medicine, has been named by the Board of Trustees of KSMA as official historian of the Association. His appointment fills the position left vacant by the recent death of Emmet F. Horine, M.D., historian since 1938.

Doctor Conner, who is book review editor of The Journal, was special editor of the November, 1963, 60th Anniversary issue. He is also chairman of the library committee for the U. of L. Medical School, where he has been on the faculty since 1957. Doctor Conner is a graduate of the University of Maryland School of Medicine.

First Mental Health Congress Registration Totals 153

The need for adequate comprehensive mental health services within the community were discussed in detail before 153 registrants at the First Kentucky Congress on Mental Health May 14 in Louisville, according to Frank L. Gaines, M.D., chairman of the KSMA Mental Health Committee.

The Congress, held at the Kentucky Hotel, was sponsored by KSMA in cooperation with the Kentucky Department of Mental Health, the Kentucky Psychiatric Association, and the Kentucky Association for Mental Health.

Kentucky Governor Edward T. Breathitt spoke on "Mental Health in Kentucky—Past and Future" at the luncheon session, presided over by George P. Archer, M.D., Prestonsburg, KSMA president, who also moderated the morning session.

Hamilton Ford, M.D., Galveston, Tex., chairman of the American Medical Association's Council on Mental Health, provided the main address of the conference. Doctor Ford told an audience of physicians and lay and professional people that "The medical profession has a clear responsibility to assume leadership in the mental health field and to work with professional and lay groups in a sustained, coordinated effort to effect sound workable mental health programs."

Also participating on the program were Howard Bost, Ph.D., Lexington, chairman of the Kentucky Mental Health Planning Commission; Harold Schupbach, M.D., Owensboro, member of the KSMA Mental Health Committee; Carlisle Morse, M.D., Louisville, KSMA vice-president (Central); William J. McGlothlin, a University of Louisville vice-president, and Joseph Parker, M.D., Lexington, president of the Kentucky Psychiatric Association.



Kentucky Governor Edward T. Breathitt, center, addressed the luncheon session of the First Kentucky Congress on Mental Health May 14 in Louisville. Also participating in the program were KSMA president George P. Archer, M.D., left, and Harld McPheeters, M.D., Kentucky Commissioner of Mental Health.



Among the speakers on the program of the first Kentucky Congress on Mental Health were, front row, left to right, Howard Bost, Ph.D., Lexington; George P. Archer, M.D., Prestonsburg, KSMA president, who presided; Joseph Parker, M.D., Louisville; and, at back, Hamilton Ford, M.D., Galveston, Tex., left, Chairman of the AMA Council on Mental Health and Harold Schupbach, M.D., Owensboro.

New Record Set for Payment Of KSMA Annual Dues

As of May 1, 1964 more than 2,000 KSMA members had remitted their 1964 KSMA dues, which, according to KSMA president George P. Archer, M.D., Prestonsburg, is a new high.

Doctor Archer pointed out that this is two percentage points ahead of the same record in 1963 and nine percentage points ahead of 1962. This he said took place in the face of the increase in dues last November. In addition, AMA remittances are two percent above this time last year.

It was suggested by Doctor Archer that more and more the members of the medical profession are realizing the need of having a strong organization dedicated to the maintenance of the free enterprise system and to continue to provide the public with the best possible medical care.

Rural Ky. Scholarship Fund Grants New Loans to Eight

Eight present and future medical students from Kentucky will receive loans in the amount of $1,300 each for the 1964-65 school year from the Rural Kentucky Scholarship Loan Fund, it was decided at a May 6 meeting of the Scholarship Board of Trustees at KSMA Headquarters in Louisville.

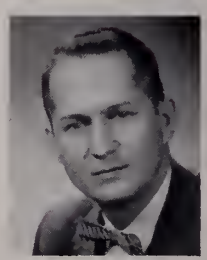
Loans of $1,300 each have also been granted to second, third, and fourth-loan applicants. This is the highest loan ever given by the fund since its inception in 1946. At the present time the Scholarship Fund has $253,000 on loan to medical students, according to C. C. Howard, M.D., Glasgow, who was re-elected chairman of the Board at the May 6 meeting.

Currently, 52 students, including the first-loan group, are participating in the Scholarship Fund program. Each recipient accepts two responsibilities to the Fund when receiving a loan. He must agree to practice in a qualifying area twelve months for each loan received, and he must repay the money at 2% interest after entering practice unless he locates in designated critical counties. In that case, one loan is cancelled for each full year of practice.

Recipients of this year's loans represent five medical schools. The University of Kentucky has 24 participating students; U. of L., 23; Tulane, 3; the University of Tennessee, 1; and Meharry Medical College, 1.



Doctor Denham



Doctor Witten

Dr. Witten New KAGP President; Academy Honors Dr. Denham

Carroll L. Witten, M.D., Louisville, was named president-elect of the Kentucky Academy of General Practice at the KAGP's meeting in Louisville May 6-8. He will take office next year, succeeding Ellsworth C. Seeley, M.D., London, who was installed at the May meeting.

The Academy also honored Mitchel B. Denham, M.D., Maysville, by naming him Kentucky Citizen-Doctor of the Year. Doctor Denham was given this same award in 1958, and is now the first physician to receive the plaque of recognition twice.

The meeting, at the Kentucky Hotel, was attended by 376 physicians from the state, who heard significant scientific discussions by ten top-ranking guest speakers from a variety of medical specialty fields.

Doctor Witten, five times speaker of the Congress of Delegates of the American Academy of General Practice, is a former president of the Jefferson County Academy and a member of the Louisville and Jefferson County Board of Health. He graduated in 1951 from the University of Louisville School of Medicine.

Doctor Denham, serving his third term in the Kentucky Legislature, was House majority leader during the 1964 General Assembly sessions. He is Trustee for KSMA's Ninth Trustee District, and 1962 recipient of the KSMA Distinguished Service award.

A 1940 graduate of the University of Louisville School of Medicine, Doctor Denham served in the U.S. Army Medical Corps in World War II. He is a member of the Mason County Board of Health and has been active in KSMA committee work.



relieves pain and relaxes muscle

TRAUMA!

Following traumatic injury, patient comfort can be increased and recovery time shortened by the simultaneous treatment of both pain and muscle spasm with 'Soma' Compound.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Also available with ¼ gr. codeine as SOMA® COMPOUND WITH CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit forming).

WALLACE LABORATORIES/*Cranbury, N.J.*

Side effects: Although there has been no evidence of tolerance, withdrawal symptoms or excessive self-medication, 'Soma' Compound and 'Soma' Compound with Codeine, like other central nervous system depressants, should be used with caution in addiction-prone individuals. While codeine addiction is relatively rare and easily broken, the same precautions must be observed as for any other opium alkaloid. Nausea, vomiting, constipation and miosis are possible codeine side effects. Should symptoms of hypersensitivity occur, discontinue medication.

Contraindications: None reported.

Complete product information available in the product package, and to physicians upon request.

Dosage: Usual dosage is 1 or 2 tablets 4 times daily.

Supplied: 'Soma' Compound is available in orange, scored tablets; bottles of 50. 'Soma' Compound with Codeine (narcotic order form required) is available in white, lozenge-shaped tablets; bottles of 50.

CSO-1054


just
turned
hypertensive

a 15 mm. Hg. drop in diastolic pressure would also suit her very well

for suitably gradual, physiologic hypotensive treatment

HYDROMOX®

QUINETHAZONE·TABLETS

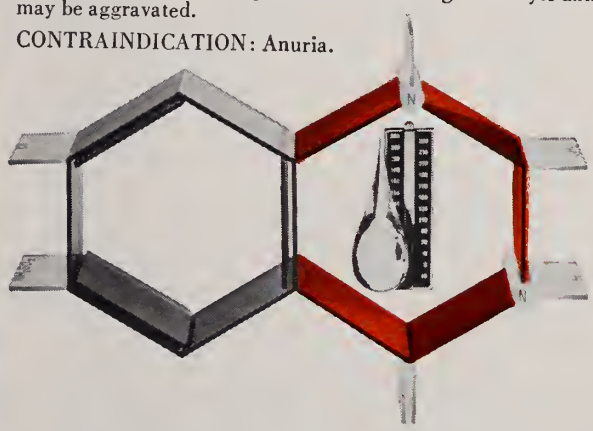
antihypertensive diuretic

HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg.,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.



1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

Lederle

LEDERLE LABORATORIES,
A Division of AMERICAN CYANAMID COMPANY,
Pearl River, New York

6278-4

NEW MEN'S SHOP



. . . in our NEW SOUTHERN

OPTICAL BUILDING, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

GUILD OPTICIANS Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
203 Parkside Building, 4140 Shelbyville Road, Louisville 7
Mailing Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884

Ky. College of Surgeons Elects Dr. Robertson New President

Robert W. Robertson, M.D., Paducah, was named president of the Kentucky Chapter, American College of Surgeons, at the Chapter's annual meeting in Louisville April 24-25.



Doctor Robertson

Doctor Robertson took over the office from outgoing president William T. Rumage, Jr., M.D., Louisville. Also elected during the meeting were Charles M. Edelen, M.D., Louisville, vice-president, and Richard R. Crutcher, M.D., Lexington, councilor.

One hundred twenty-five physicians registered for the two-day scientific and business session held at Stouffer's Louisville Inn. A time and place for next year's meeting have not been set.

McDowell House Receives Gifts From Medical Auxiliaries

The Ephriam McDowell House in Danville, a shrine dedicated in memory of one of Kentucky's pioneer physicians, has recently been the recipient of several gifts of cash and furnishings, according to Laman A. Gray, M.D., chairman of the McDowell House Memorial Committee of KSMA.

Mrs. Walker Owens, Mt. Vernon, chairman of the McDowell House Committee of the KSMA Woman's Auxiliary, has reported cash gifts, from the Fayette County Medical Auxiliary in memory of Charles A. Vance, M.D., and from the Boyle County Auxiliary in memory of Mrs. Charles W. Caldwell, deceased wife of Charles Caldwell, M.D. Both donations will be used for additional furnishings for the McDowell House.

A valuable Persian Hadjii rug, the gift of the KSMA Auxiliary, will be used in the living room of the McDowell House. The shrine also received a Sandwich glass table lamp from the Colonial Dames of America. Chapter IX.

U.L. Medical Alumni Elect

Hollis Johnson, M.D., Louisville, was recently named president-elect of the University of Louisville Medical Alumni Association, according to information released by Walter S. Coe, M.D., Louisville, current president. Doctor Johnson will take office in January, 1965.

Also elected were: Frank A. Bechtel, M.D., Louisville, vice-president; Henry S. Collier, M.D., Louisville, secretary-treasurer; and O. J. Hayes, M.D., and John Auldin Bishop, M.D., both of Louisville, councilors.

Dr. Massie Gets Honorary Degree

Francis M. Massie, M.D., Lexington surgeon, received an honorary doctor of science degree from Transylvania University at the school's June 7 commencement exercises.

Doctor Massie, clinical professor of surgery at the University of Kentucky College of Medicine, was recognized for his contributions in the field of medicine. He was a recipient, in 1959, of the KSMA Distinguished Service Award.

Dr. Johnston New President Of Ky. Surgical Society

Coleman C. Johnston, M.D., Lexington, was chosen president of the Kentucky Surgical Society during its annual scientific and business meeting held this year at Nashville May 15-16 in cooperation with the department of surgery at Vanderbilt University School of Medicine.

Doctor Johnston will succeed Delmas M. Clardy, M.D., Hopkinsville, in office. Jacob J. Mayer, M.D., Mayfield, was elected vice-president. Secretary Blaine Lewis, M.D., Louisville, is currently serving the third year of a three-year term.

The limited-membership society also elected six new members to bring its roster to 125. New members are: Robert R. Burnam, M.D., Alvin Lebendinger, M.D., Kenneth H. McCrocklin, M.D., William J. Sandman, M.D., all of Louisville; Gordon L. Hyde, M.D., Lexington, and Gerald B. Reams, M.D., Ashland.

Plans have been made to hold next year's meeting at Louisville in cooperation with the U. of L. department of surgery. In 1962 the Society met at the University of Cincinnati, and in 1963 at the University of Kentucky at Lexington.



With Coleman C. Johnston, M.D., center, new Kentucky Surgical Society president, are Blaine Lewis, M.D., left, who is serving the third year of a three-year term as secretary of the Society, and out-going President Delmas M. Clardy, M.D. Doctor Johnston was elected at the Annual meeting of the Society in Nashville last month.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

IN KENTUCKY

JUNE

11	Monthly Anesthesiology Postgraduate Seminar, University of Kentucky, Lexington, Ky.
18	KAGP Seminar, Henderson, Ky.

JULY

22-23	Cumberland Valley Seminar, KAGP, S.E. Kentucky Baptist Hospital, Corbin, Ky.
25-26	Community Disaster Planning, AMA Committee on Disaster Medical Care, Stouffer's Inn, Louisville, Ky.
30	West Kentucky Seminar, KAGP, Irvin Cobb Hotel, Paducah, Ky.

AUGUST

13	KAGP Seminar, Bardstown, Ky.
29-30	Bluegrass Seminar, KAGP, Lexington, Ky.

SEPTEMBER

12	Internal Medicine, American College of Physicians, Joint Meeting of Kentucky and Tennessee, Louisville, Ky.
29-Oct. 1	KSMA ANNUAL MEETING, Convention Center, Louisville, Ky.

SURROUNDING STATES

JUNE

14-19	7th Inter-American Congress of Cardiology, Montreal, Canada.
17-21	Refresher Course in Diagnostic Radiology, University of Cincinnati, Cincinnati, Ohio.
18-19	American Pediatric Society, Seattle, Wash.
18-22	American College of Chest Physicians, San Francisco, Calif.
19-20	American Geriatrics Society, San Francisco, Calif.
21-25	American Medical Association, San Francisco, Calif.

JULY

10-11	18th Annual Rocky Mountain Cancer Conference, Denver, Colo.

AUGUST

24-27	American Hospital Association, Palmer House, Chicago, Ill.
24-27	American Academy of Physical Medicine and Rehabilitation, Statler-Hilton, Boston, Mass.
25-28	American Association of Blood Banks, Washington, D.C.

SEPTEMBER

9-12	International College of Surgeons, Chicago, Ill.
10	10th Annual Medical Symposium, Cabell County Medical Society, Frederick Hotel, Huntington, W. Va.
17-19	5th Annual Cancer Conference, American Cancer Society and National Cancer Institute, Philadelphia, Pa.
26-27	Congress on Occupational Health, AMA, Rice Hotel, Houston, Tex.

SUBMIT DATES OF PG MEETINGS

From now to the end of the year, many medical organizations are selecting dates for next year's meetings. Some are already selecting topics and speakers and planning programs.

The Continuing Medical Education Office of KSMA would like to urge these societies and organizations to notify this office of the dates and topics, so they can be added to the "Continuing Educational Opportunities" page in The Journal. In this manner we hope to avoid conflicts in dates and to inform a large audience of these up-coming meetings.

You are urged to submit this information to the KSMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205

a cry in the night?

But that low back pain needs attention, too!



Robaxin
(methocarbamol, Robins)

U.S. Pat. No. 2770649

Successful clinical experience with ROBAXIN (methocarbamol) in thousands of cases of musculoskeletal disorders is reflected by numerous published reports. Side effects (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. Contraindicated in hypersensitive patients.

Average Adult Dose

	ROBAXIN® (methocarbamol, 500 mg./tab.)	ROBAXIN®-750 (methocarbamol, 750 mg./tab.)
Initially	3 tablets q.i.d.	2 tablets q.i.d.
Maintenance	2 tablets q.i.d.	1 tablet q.4 h. or 2 tablets t.i.d.

A. H. ROBINS CO., INC., Richmond 20, Virginia


There's nothing
like a vacation*
for relaxing stress-induced
smooth muscle spasm

...nothing, that is, except the sedative-antispasmodic action of

Donnatal®

Robins

Prescribed by more physicians than any other antispasmodic —well over 5 billion doses!

In each Tablet, Capsule or 5 cc. Elixir		In each Extentab
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital	(¾ gr.) 48.6 mg.

(Warning: May be habit forming)

Under the pressure of modern living, with its "small continued anxieties of life,"[6] functional disturbances of secretion, tone and motility of the gastrointestinal tract are extremely common.[6,8] For the relief of symptoms associated with such disturbances—through rest for the patient, rest for the colon[3]—the drugs of greatest value have proved to be the antispasmodics and the sedatives.[3,6,7]

DONNATAL—a dependable, time-tested combination of natural belladonna alkaloids and phenobarbital—has produced excellent results in relieving visceral spasm.

DONNATAL makes peptic ulcer patients "quite comfortable"[8]...relieves epigastric pain and discomfort[2]...gives "marked relief" in spasm and irritation of the g.i. tract[5]...offers "quite high and predictable" efficiency in alterations of motility associated with gas and cramping[1]...in short, has a definite place in the physician's armamentarium because of "convenience of dosage regulation, effectiveness, safety, and economy."[4]

INDICATIONS: DONNATAL is indicated in recurring, persistent or chronic visceral spasm, as in peptic ulcer, pylorospasm, irritable stomach and colon, motion sickness, nocturnal enuresis, mucous colitis and diarrhea.

SIDE EFFECTS: No serious toxic reactions are to be expected. Dryness of the mouth, blurred vision, difficult urination, and flushing and dryness of the skin may occur with excessive and prolonged dosage.

PRECAUTIONS: Patients with incipient glaucoma or urinary bladder neck obstruction must be treated with care, as with any preparation containing a parasympathetic depressant.

CONTRAINDICATIONS: DONNATAL is contraindicated in acute glaucoma, advanced hepatic or renal disease, and known or suspected idiosyncrasy to any of its components.

REFERENCES:

1. Asher, L.M.: Am. J. Digest. Dis. 4:260, 1959.
2. Barden, F.W., Hill, P.S., Mahaney, W.F., and Cuneo, K.J.: J. Maine M.A. 45:11, 1954.
3. Donovan, E.J.: Rocky Mt. M.J. 50:952, 1953.
4. Hock, C.W.: Clinical Med. 8:1932, 1961.
5. Marks, L.: Am. J. Gastroenterol. 27:180, 1957.
6. Palmer, W.L., and Kirsner, J.B.: Therapeutics in Internal Medicine, 2nd ed., F. A. Kyser, ed., Hoeber, New York, 1953, p. 368.
7. Watts, M.S.M., and Wilbur, D.L.: J.A.M.A. 152: 1192, 1953.
8. Wharton, G.K., Balfour, D.C., Jr., and Osmon, K.I.: Postgrad. Med. 21:406, 1957.

A. H. ROBINS COMPANY, INC., RICHMOND 20, VIRGINIA

*This one at Olympic National Park, Washington.



New officers installed at the May 17 business meeting of the Kentucky State Association of Medical Assistants included, from left, Mrs. Zelma Harrod, recording secretary; Miss Libby Curtsinger, corresponding secretary; Mrs. Claire Demarest, treasurer; Mrs. Bettye Fisher, Evansville, Ind., past president of the national organization, who installed the officers; Miss Dorothy Downs, president; and Mrs. Wanda Taylor, president-elect.

Ky. Medical Assistants Assn. Installs New Officers

Mrs. Wanda Taylor was named president-elect and Miss Dorothy Downs was installed as 1964-65 president of the Kentucky State Association of Medical Assistants at the group's second annual meeting in Louisville May 16 and 17. Both are from Louisville.

George Sehlinger, M.D., president of the Jefferson County Medical Society, was one of the speakers at the Saturday morning educational seminar. "Efficiency Plus Purpose — Practice — Progress — Participation", was the overall theme of the two-day convention held at the Kentucky Hotel.

Sharing the Saturday program with Doctor Sehlinger were Robert Cooper, M.D., Louisville; Dave Greenwell, Louisville, Blue Cross-Blue Shield Plan; and Thomas Girvin, Dayton, O., medical economics consultant. Herbert E. Ashby, Evansville, spoke at the banquet that evening.

Carlisle Morse, M.D., vice-president (Central) and Jack L. Chumley, M.D., chairman of the advisory board of the KSAMA, spoke at the Sunday luncheon following the business session.

Mrs. Bettye Fisher, past president of the American Association of Medical Assistants, installed the officers, who also include Mrs. Phoebe Faust, Louisville, vice-president; Mrs. Zelma Harrod, Frankfort, recording secretary; Miss Libby Curtsinger, Louisville, corresponding secretary; and Mrs. Claire Demarest, Louisville, treasurer.

Dr. Van Meter on YMCA Council

J. Farra Van Meter, M.D., Lexington, was elected to serve a second year as president of the Southern Area Council of the YMCA at the council's 25th annual meeting held in Miami, Fla., April 30-May 2.

Ky. Ob-Gyn Society Elects

Edwin P. Soloman, Jr., M.D., Louisville, was elected president of the Kentucky Obstetrical and Gynecological Society at the Society's annual meeting at Stouffer's Louisville Inn May 7-9. Also elected were Albert Woolsey, M.D., Harlan, vice-president, and Philip H. Crossen, M.D., Lexington, secretary-treasurer.

Featured guest speakers on the scientific program of the three-day meeting were Lawrence L. Hester, M.D., professor and chairman of the department of Obstetrics and Gynecology at the Medical College of South Carolina at Charleston, and Col. William F. Peterson, M.D., of the U.S. Air Force Hospital at Andrews Air Force Base, Maryland.

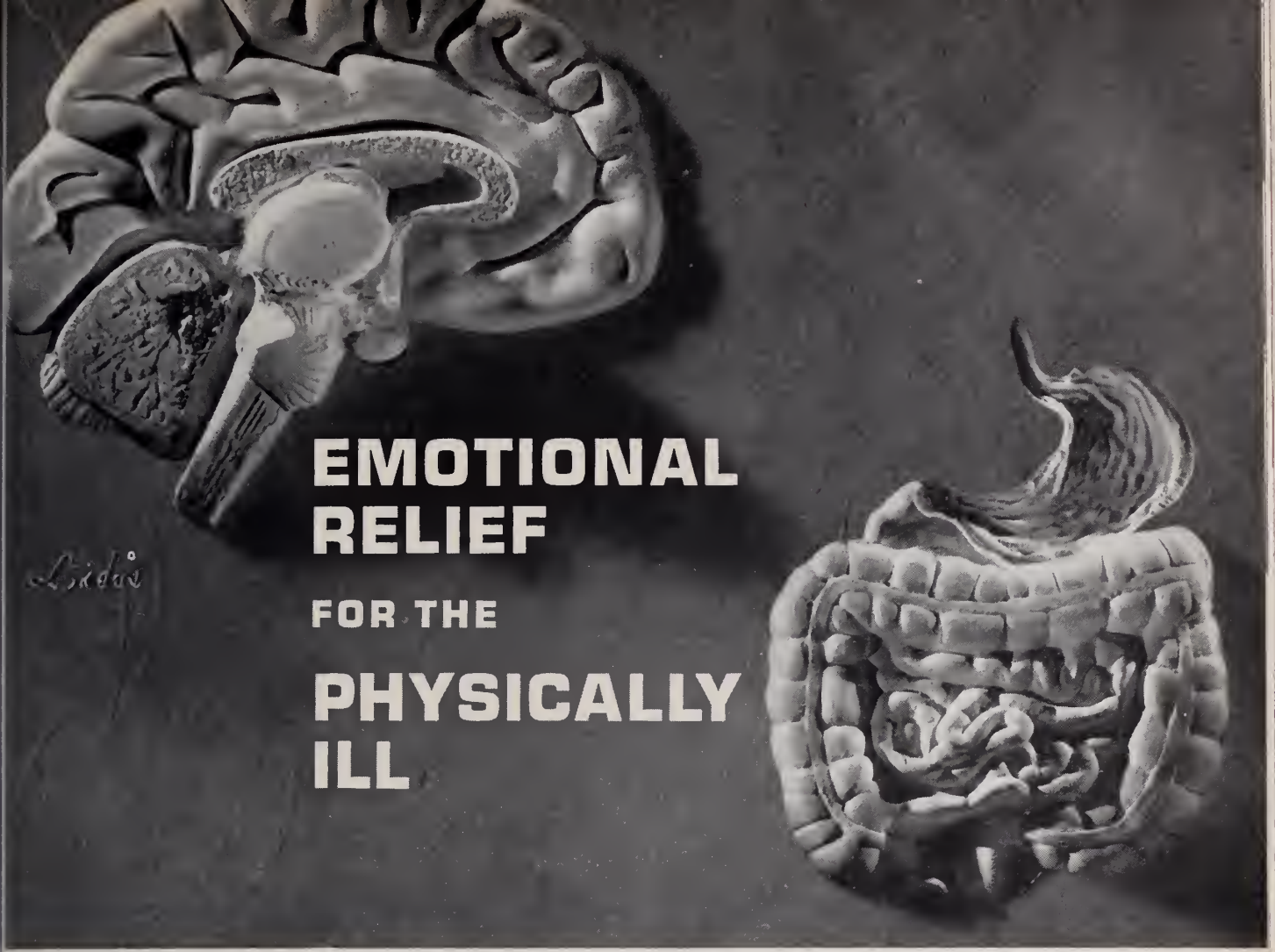
Doctors Serve on College Boards

Two KSMA members, W. H. Cartmell, M.D., Maysville, and W. Gerald Edds, M.D., Calhoun, have been reappointed by Governor Edward Breathitt to the Board of Regents of Kentucky State colleges.

Doctor Cartmell was reappointed to a four-year term on the Morehead State College Board of Regents. Doctor Edds has been appointed to his second four-year term as a member of the Board of Regents of Western Kentucky State College. Dr. Cartmell is currently serving as president of the Board of Directors of the Kentucky Blue Shield Plan.

W.Va. Medical Symposium Set

The 10th Annual Medical Symposium sponsored by the Cabel County Medical Society will be held this year at the Frederick Hotel, Huntington, W. Va., on September 10. The topic of this year's meeting will be "Pulmonary Disease". For further information contact Joseph M. Ferrell, M.D., First Huntington National Bank Building, Huntington, W. Va.



RELIEVES ANXIETY, APPREHENSION AND TENSION...



All day long
. . . keeps the patient calm, and the mind clear.



All night too
. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400

(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

©ME-805

WALLACE LABORATORIES *Cranbury, N. J.*

News Items

C. A. Waldemayer, M.D., Butler, Ky., has announced that he has discontinued the private practice of medicine in order to go into full-time public health work. He will be public Health officer for Bracken, Gallatin, Grant, Pendleton and Robertson Counties.

Robert P. Schiavone, M.D., will open an office in Louisville July 1, according to a recent announcement. A 1961 graduate of the University of Louisville School of Medicine, Doctor Schiavone has been in general practice at Owenton since 1962.

R. H. Weddle, M.D., Somerset, recently participated in a finance campaign project of the Blue Grass Council of Boy Scouts, Lake Cumberland District. Doctor Weddle is special gifts chairman of the Council.

George M. Lawson, M.D., has joined the staff of the Methodist Evangelical Hospital in Louisville, where his practice will be limited to radiology. A 1957 graduate of the University of Louisville School of Medicine, Doctor Lawson interned at Philadelphia General Hospital and was a resident at Yale University, where he served last year as an instructor in radiology.

Elbert L. Dennis, M.D., who has been in practice in Louisville for 21 years, will start on July 1 a surgical residency at J. Hillis Miller Medical Center at the University of Florida at Gainesville.

Robert C. Long, M.D., Louisville, has become a life master at contract bridge. A member of the AMA Board of Trustees, Doctor Long, whose tournament participation is limited by his professional obligations, acheived the life master rating during a recent regional tournament in Indianapolis.

Gradie R. Rowntree, M.D., Louisville, received the Meritorious Service Award of the Industrial Medical Association at the association's 49th annual meeting held April 13-16 in Pittsburgh, Pa. Doctor Rowntree, medical director of the Fawcett-Dearing Printing Company in Louisville, was cited for his contribution in forming eight new component societies, and his promotion of occupational health.

James S. Brashear, M.D., Central City, has announced the opening of his office in that city for the practice of general medicine. Doctor Brashear, who graduated in 1961 from the University of Louisville School of Medicine, interned at St. Joseph Infirmary, Louisville.

W. E. Davis, M.D., North Middletown, was presented a Master Conservationist award April 2 at a meeting of the Bourbon County Soil Conservation District at Paris.

Robert S. Bain, M.D., who until recently served as full-time obstetrician at the Whitesburg Hospital, has resigned from that position to enter private practice in the South.

Members of **Alpha Kappa Kappa** medical fraternity at the University of Louisville will have a new house on Gray Street next year, according to Edward Warrick, Jr., M.D., head of the Doctor John W. Fish Memorial Foundation, in charge of the building plans. Construction on the new house was begun in May under the direction of the Foundation, made up of AKK alumni. The old house burned last April.

Class Reunion Chairmen Named

Chairmen have now been named for nearly all of the 10 class reunions for medical alumni of the University of Louisville, scheduled to be held during the KSMA Annual Meeting September 29-October 1 in Louisville.

Chairmen and their respective reunion classes are: 1934—H. Davis Chipps, M.D., Lexington; 1939—Herbert L. Clay, Jr., M.D., Louisville; 1944—Charles O. Bruce, Jr., M.D., Louisville; 1949—Charles Floyd, M.D., Gulfport, Miss.; 1954—Milton F. Miller, M.D., Louisville; 1959—Morton F. Wolfe, M.D., New Albany. The classes of 1914, 1924, and 1929, which will hold reunions, have not yet named chairmen. Additional information on class reunions will be released in The Journal as it becomes available.

U.L. Alumni Entertain Seniors

The alumni of the University of Louisville School of Medicine held their third annual dinner for graduating seniors of the medical school on May 29 at the Medical Arts Building in Louisville. The graduates and their wives heard addresses by William McGlothlin, Ph.D., vice-president of the University, and Donn L. Smith, M.D., dean of the School of Medicine.

The annual dinner party is given for the purpose of welcoming the current graduates into the Alumni Association, one of the oldest and largest organizations of its kind in the country. The U. of L. Medical Alumni group has roughly 4,000 members and is represented by members in every state in the United States and almost every country in the world.

test yourself

How much does the average American spend each year on these?

TOBACCO	ALCOHOL	R_X DRUGS
		
☐ $19	☐ $36	☐ $141
☐ $63	☐ $84	☐ $76
☐ $42	☐ $57	☐ $13

Score yourself 100% if you checked the bottom figure in each column. Yes, the U.S. Department of Commerce reports that 1962 per capita expenditure was $42 for tobacco, $57 for alcohol, only $13 for prescription drugs. That's about 25 cents per week per person for drugs that helped them stay well, get well, or possibly helped save their lives. Can you think of a bigger bargain?

Your patients might like to take this test, too. May we send you 25 copies for your waiting room?

Pharmaceutical Manufacturers Association — 1411 K Street, N.W., Washington, D.C. 20005

This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

Ky. Pediatric Society Elects Dr. Cunningham President

Guy C. Cunningham, M.D., was elected president of the Kentucky Pediatric Society May 13 at the Medical Arts Building in Louisville during a joint two-day meeting with the Kentucky Chapter, American Academy of Pediatrics.

Doctor Cunningham succeeds Harry S. Andrews, M.D., Louisville, as president of the organization.

Other officers elected at the meeting were William D. Bushong, M.D., Owensboro, vice-president, and William F. Schnitzker, M.D., Ashland, Secretary-treasurer.

Dr. Ransdell to Head KTS IN '65

Herbert T. Ransdell, Jr., M.D., associate professor of thoracic surgery at the University of Louisville School of Medicine, was chosen president-elect of the Kentucky Thoracic Society at its annual meeting April 23 in Louisville.

He will succeed Jerome E. Cohn, M.D., director of the pulmonary division at the University of Kentucky College of Medicine, who was installed as 1964 president at the same meeting. Isadore Zapolsky, M.D., Paris, was elected secretary-treasurer.

Birth and Death Certificates Cost to Rise After July 1

Beginning July 1, 1964, the price of birth and death certificates registered with the Office of Vital Statistics, Kentucky State Department of Health, will be $2.00, Lewis C. Bush, director, has announced.

Birth and death certificates may be obtained before July 1 for $1.00 by writing the Office of Vital Statistics, 275 East Main Street, Frankfort, Kentucky. After this date be sure to enclose $2.00 so there will be no delay in receiving these certificates.

Parents who have children entering school for the first time, joining Little League teams, applying for driver's licenses, and voting for the first time need certified copies of their children's birth certificates for these activities and many others. Death certificates are equally important in settling estates and insurance claims.

FOR RENT:

Fully equipped and handsomely furnished office (1000 square feet) in the two-year old Southern Parkway Medical Center, Louisville, with 5 MD's, 1 dentist, 1 orthodontist, full X-Ray Department, Diagnostic Laboratory and Apothecary. Office contains files of an extensive and well established practice. Owner leaving to do a residency.

Tel. 361-2414 893-3112
895-0596 893-7093

Dr. Christopherson on Program

William M. Christopherson, M.D., professor and chairman of the department of pathology at the U. of L. School of Medicine, will participate on the program of the 18th Annual Rocky Mountain Cancer Conference in Denver, July 10-11. Information on the conference may be obtained from the Rocky Mountain Cancer Conference, 1809 E. 18th Ave., Denver, Colo. 80218.

Dr. Maxwell Heads TB Assn.

Edward N. Maxwell, M.D., Louisville Radiologist, was installed as president of the Kentucky Tuberculosis and Respiratory Disease Association at the Association's annual meeting April 23-24 in Louisville. The organization, formerly the Kentucky Tuberculosis Association changed its name during the two day meeting held in conjunction with the meeting of the Kentucky Thoracic Society.

Ky. M.D. Addresses Educators

Clyde T. Moore, M.D., Fern Creek general practitioner, told of Jefferson County School District's progress in providing advanced programs for gifted children in an address before the convention of National School Boards at Houston, Tex., April 27. Doctor Moore is currently serving his fourth year as a member of the Jefferson County Board of Education.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

(Research and Teaching Exhibits)

1964 Annual Meeting — Kentucky State Medical Association

Convention Center — **Louisville, Kentucky** — **Sept. 29, 30; Oct. 1**

Fill Out and Mail to:

BENJAMIN B. JACKSON, M.D., Chairman

Committee on Scientific Exhibits

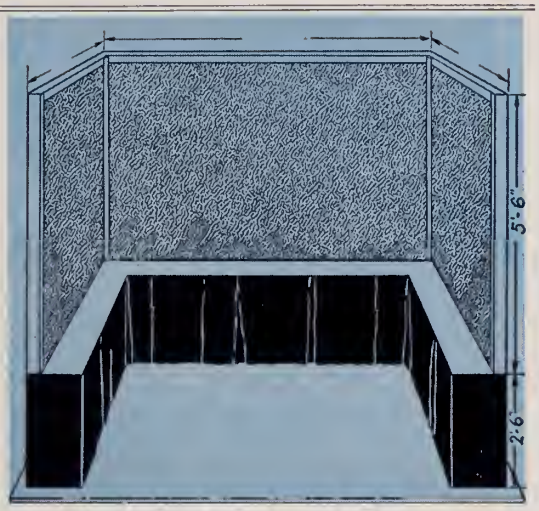
Kentucky State Medical Association

3532 Janet Avenue

Louisville, Kentucky 40205

Applications for space should be received before July 1, 1964

Dimensions and structure of KSMA Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....
2. Name (s) of Exhibitor (s): (AMA Member?) .....

   .....

   Institution (if desired): .....

   Mailing Address .....
3. Do you have a built-in exhibit? .....
4. Description of Exhibit: (Attach Brief Description Not To Exceed 100 Words to this blank)
5. Exhibit will consist of the following: (Check which)

   Charts and Posters.... Photographs.... Drawings.... X-rays....

   Specimens.... Moulages.... Other Material ..... (Describe)
6. Booth Requirements:

   Amount of wall space needed? .....

   Back wall .....Side walls (All side walls are 4') .....

   Square feet needed? .....Shelf desired? (yes or no) .....
7. Indicate sources of assistance provided in connection with the exhibit. .....
8. Has this exhibit been exhibited before? If so, when & where? .....

Date ....

Signature of Applicant

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual KSMA meeting.

Due to the shortage of space, please have your exhibit as compact as possible.



THE INSURANCE PAGE



Health Insurance in Kentucky

THE people of Kentucky have reached a high level in health insurance protection. As of December 31, 1962, 60% of the state's population were covered by some form of health insurance for the costs of hospital and medical care. This compares with the national figure of 76% of the civilian population—some 141 million persons—having health insurance.

The following data was recently compiled by the Health Insurance Institute:

Extent of Health Insurance Coverage and Other Figures

—Number of persons with hospital expense insurance 1,850,000*
—Number of persons with surgical expense insurance 1,748,000*
—Number of persons with regular medical expense insurance 1,321,000*
—Number of persons with major medical insurance 350,000*
—Total health insurance benefits paid (1961) $69,431,000
By insurance companies for hospital, surgical, and medical care, including loss of income $34,055,000
By Blue Cross-Blue Shield and other plans for hospital, medical, and surgical care $35,376,000

—Number of health insuring organizations licensed in the state 267
(261 insurance companies, 2 Blue Cross-Blue Shield and similar groups, and 4 other health plans)

Net total of people protected—eliminates duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage.

Hospital Statistics

—Number of hospitals** in state (1962) 106
—Number of hospital beds available (1962) 9,676
—Number of persons admitted during the year (1962) 406,068
—Number of persons under hospital confinement on an average day 7,162
—Average length of time patient remained in hospital .....6 days
—Average cost per hospital stay ...$206.78

Professional Services

—Number of practicing physicians (1962) 2,132
—Number of practicing dentists (1962) 1,128
—Number of registered pharmacists (1962) 1,595

***Nonfederal, short-term general and other hospitals.*



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

313-4

PUBLIC HEALTH PAGE

Mobile X-Ray Units*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health, Commonwealth of Kentucky

IN the fall of 1961, we began asking for a report of the final diagnosis made on patients whose miniature chest films were reported as showing abnormal shadowing.

A study of the final diagnoses has now been made for abnormal films taken during 1962.

We took 96,372 miniature films and reported 6,431 as suspicious (tuberculosis to be excluded) with a request for the final diagnosis to be reported.

Of these 6,431, we have received final diagnoses on 1,980 or 30.8% from the family physician or health department. Following is a tabulation of the diagnoses reported, together with a projection of the diagnoses in the 6,431 total.

Final diagnosis reported New cases of tuberculosis	Actual in 1980 reported	Estimated in 6,431 total
Active	63	200
Activity Questionable	30	100
Inactive	218	700
TOTAL	311	1,000
Suspect Tuberculosis	46	225
Heart Disease	32*	100*
Pulmonary Malignancy	18	60
Other Significant Diseases	517	1,675

**In addition to 262 reported from miniature film*

The other cases were reported as "negative," "no tuberculosis," "O. K.," or "no active disease," or some equivalent term.

Some diagnoses—such as "O. K." or "no active disease"—are vague and may represent almost anything from inactive tuberculosis to negative.

To sum up, we found one new active case of tuberculosis for every 480 miniature films. This is an extremely high return, and demonstrates clearly the importance of this program as a means of finding tuberculosis cases, to say nothing of the many other respiratory and cardiac abnormalities brought to the attention of the physician. It also indicates the importance of following up the abnormal films reported.

The miniature film is an inexpensive and convenient type of chest x-ray for screening purposes. It is not intended to be a diagnostic film. However, it should not be considered as inferior to a 14x17 film because it is cheap and convenient. Basically, the P.F.X. film merely indicates whether or not there is a lesion requiring further attention and it does this with great reliability. Any further investigation needed is the responsibility of the family physician.

This service is tax-supported and is entirely free and we hope you will make free use of it by referring any or all your patients when the unit is in your county. However, known cases of tuberculosis should *never* be referred for P.F.X. films, nor those who have demonstrable pulmonary disease, as they will merely be referred back for 14x17 films.

We would be very grateful if you would report the results of your follow-up promptly and precisely, avoiding vague terms like "O. K." and "no active disease." Please give the reference number, as well as the patient's name.

It is very important that we should be able to evaluate the results of this program constantly so we can make the best use of these units. Your reports are the only means of evaluation we have, so we earnestly request your help.

**This article was prepared by M. Stuart Lauder, M. D., C. M. Director, Tuberculosis Control Kentucky State Department of Health Frankfort, Kentucky*

County Society Reports

McCracken

Sim F. Beam, M.D., St. Louis, presented a paper on "Lesions of the Jejunum," as the scientific program at the regular meeting of the McCracken County Medical Society held February 26 at Boswell's Restaurant in Paducah.

The society voted to accept Eli Khouri, M.D., Paducah, as a new member.

A letter from L. E. Albritton, president of the Paducah Association of Retail Druggists was read. It stated that their group has approved a recommendation that all refill prescriptions marked *prn* will be rechecked with the prescribing physician's office at least every six months.

In other business, the society voted to publish an advertisement in the Paducah Sun-Democrat similar to that appearing recently in the Courier-Journal regarding the pitfalls of the King-Anderson Bill. The members also went on record as opposing the establishment of a local Pediatric Clinic, since existing facilities of this type are already available in the area.

Trigg

Thornton E. Bryan, Jr., M.D., Cadiz, is serving this year as president of the Trigg County Medical Society. Other officers for the current term are: John Futrell, M.D., vice-president; and Elias N. Futrell, M.D., secretary-treasurer. Both are from Cadiz. Doctor John Futrell will serve as delegate to the Kentucky State Medical Association, and Doctor Bryan as alternate delegate.

Washington

Richard A. Hamilton, M.D., Springfield, will represent Washington County physicians in 1964 as president of the County Medical Society, according to a recent report. Other officers are Marcus A. Coyle, M.D., vice-president, and Harold B. Simms, M.D., secretary-treasurer, both of Springfield. The KSMA Delegate and alternate had not been elected at press time.

Woodford

Norman S. Fisher, M.D., Midway, will act as president of the Woodford County Medical Society during the coming year, it was recently reported. Francis D. Willey, M.D., Versailles, current vice-president, will succeed Doctor Fisher as president in 1965. W. J. Graves, M.D., Versailles, was named secretary-treasurer for the current term. Doctor Fisher will also serve as delegate to the Kentucky State Medical Association, with Doctor Willey as his alternate.

AMA Retirement Film Available

An informational sound film explaining the AMA Members' Retirement Plan is now available from the AMA Film Library. Requests for the film, designed for showing at the county society level, should be addressed to the AMA Film Library, American Medical Association, 535 N. Dearborn St., Chicago, Ill. Please indicate a choice of two or three screening dates.

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



KOAGAMIN®

parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

CHATHAM PHARMACEUTICALS, INC.
Newark 2, New Jersey
Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

County Charters Available

Any county medical society unable to find its charter and wishing to have a duplicate charter issued may have this done by applying to the KSMA Headquarters Office.

This action was voted at a recent meeting of the Executive Committee of the Board of Trustees of KSMA.

S.S. Hope Headed for Guinea

The teaching-training hospital ship S.S. Hope will begin its first medical mission to Africa on October 15, when it arrives in Conakry, Guinea, to begin a ten month visit there. Two Louisville physicians, John C. Weeter, M.D., and Ludwig H. Segerberg, have recently returned from two months of voluntary duty aboard the Hope at Guayaquil, Ecuador.

AMA Publishes Movie Catalog

Medical and Surgical Motion Pictures, recently published by the American Medical Association, lists over 3,000 available motion pictures dealing with every phase of the healing arts.

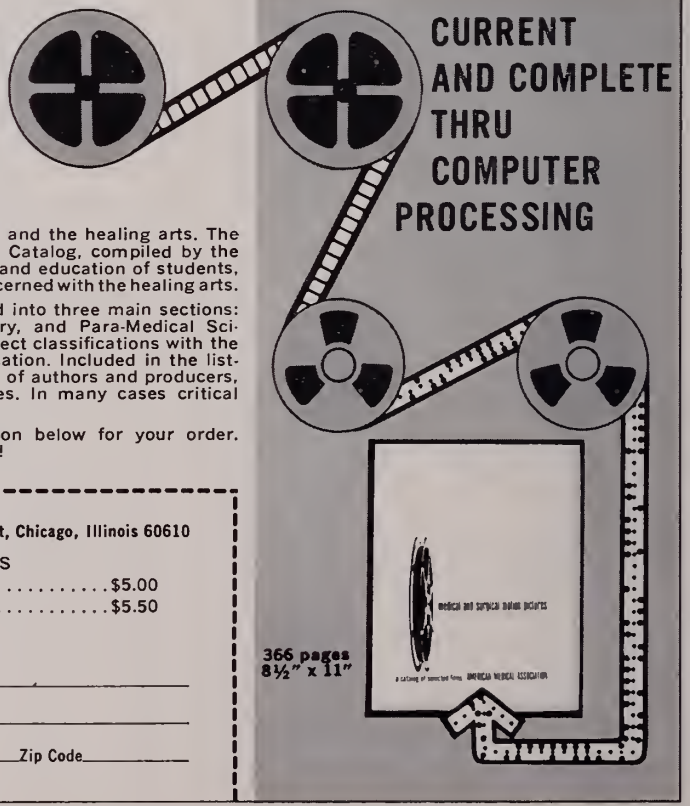
The film listings are divided into three general categories: basic sciences, clinical medicine, and surgery. It is then subdivided into some 600 specialty subjects. The films are listed alphabetically. Further information may be obtained by writing to the AMA.

Information for World Travel

If you are planning foreign travel, you are urged to check with your travel bureau on the various immunizations and precautions which should be taken prior to embarkation. The U. S. Department of Health, Education and Welfare has issued a memorandum to all travel agencies on the subject of "Health Information for International Travelers—Summer 1964".

Before enactment of the Drug Amendments of 1962, five to six years were required on the average to place a truly new drug on the market. Now, if the current law and regulations stand, or if there are lacking the right interpretation and regulatory practice, it may well take a decade or longer. The real impact of the 1962 amendents, then, may be felt in the forthcoming decade, not this year or next. Thus, the tempo of discovery and development of new drugs could be set back for years. Other products, too, could be delayed until the log jam breaks. There are some who have expressed the hope that no one dies or suffers unnecessarily during this period for lack of a drug that is not there but could have been if the channels of discovery and distribution were not riddled with hindering laws, regulations, or misunderstanding.—Austin Smith, M.D., President, Pharmaceutical Manufacturers Association, in *Southern Medical Bulletin,* December 1963.

ama's new catalog of
MEDICAL AND SURGICAL
MOTION PICTURES
over 3000 films listed



FILMS LISTED cover every aspect of medicine and the healing arts. The MEDICAL AND SURGICAL MOTION PICTURES Catalog, compiled by the AMA, can be an invaluable tool in the training and education of students, nurses, graduates, physicians and all others concerned with the healing arts.

HANDY REFERENCE . . . The catalog is divided into three main sections: Basic Sciences, Clinical Medicine and Surgery, and Para-Medical Sciences. It is then subdivided into some 600 subject classifications with the films listed alphabetically under each classification. Included in the listings are a brief summary, running time, names of authors and producers, and the address of the primary rental sources. In many cases critical evaluations are included.

ORDER TODAY, ONLY $5.00.* Use the coupon below for your order. Please include your remittance with the order!

American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610

MEDICAL AND SURGICAL MOTION PICTURES

☐ *U.S., U.S. Posssessions and Canada.....$5.00
☐ All other countries.....$5.50

____No. of copies____Total remittance

Name_____

Address_____

City_____State_____Zip Code_____



■ PETN (pentaerythritol tetranitrate) to increase oxygen supply

■ plus meprobamate to decrease anxiety and tension

Unlike phenobarbital, meprobamate is *not* cumulative and does *not* cause depression.

Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Precautions: Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Contraindications: Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* Dosage: 1 to 2 tablets, *before meals* and at bedtime. Individualization required. Supplied: Bottles of 50 tablets.

CML-1055

MILTRATE®

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

KSMA Council and Committee Reports

General Practice Committee

Homer B. Martin, M.D., Louisville, Chairman

Kentucky Hotel **May 6, 1964**

The General Practice Committee discussed in detail Resolution M, passed by the 1963 KSMA House of Delegates, (pertaining to the shortage of general practitioners). Reports were heard from representatives of the two medical schools concerning programs to interest medical students to enter general practice, and the Committee members expressed their feeling that Resolution M had been implemented in both the University of Louisville School of Medicine and the University of Kentucky Medical Center.

The Committee members also discussed the result of a questionnaire that had been sent to KSMA members who are now practicing a specialty but at one time were general practitioners. Several suggestions were made for next year's committee. Prior to adjournment, the Chairman congratulated the Committee members for being 100% in attendance.

School Health Committee

R. E. Davis, M.D., Central City, Chairman

Lexington, Kentucky **April 2, 1964**

Imperial House

The School Health Committee met for its second time this associational year and had as its guest Mr. Don Bale, Assistant Superintendent of Public Instruction for the Commonwealth of Kentucky.

The main item of discussion was the committee members' interest in seeing a state-wide physical fitness program in Kentucky schools become a reality.

A symposium on "Athletic Injury Prevention" was also finalized for the KSMA 1964 Annual Meeting. Appearing on the program will be Thomas Shaffer, M.D., Columbus, Ohio, and O. B. Murphy, M.D., Lexington.

Tuberculosis Committee

J. Ray Bryant, M.D., Louisville, Chairman

KSMA Headquarters **Thursday, April 16,1964**

A tuberculin testing program in Kentucky schools was the main item discussed by the KSMA TB Committee at their recent meeting.

The purpose of the program is to eliminate TB from schools, find here-to-fore unknown cases of TB, demonstrate the practicability of skin testing, and emphasize that TB is still a major health problem.

Members of the committee requested that the chairman recommend approval of this program in his final report to the KSMA House of Delegates.

Florida Sets Diabetes Seminar

The Florida Diabetes Association will conduct its annual seminar on Diabetes and Related Endocrine Disorders Sept. 30-Oct. 2 at the Balmoral Hotel, Miami Beach. Registration is limited to 125. Registration fee of $20 should be sent to George F. Schmitt, M.D., 30 S.E. 8th Street, Miami, Fla.

GET IN THE
MIDDLE of THINGS . . .

Heyburn Building

The preferred professional address

A central location at the hub of public transportation; adequate nearby parking. Complete service with uniformed attendants.

All specialties are represented in The Heyburn Building. This has proven to be most helpful where consultation is indicated.

For information, contact:

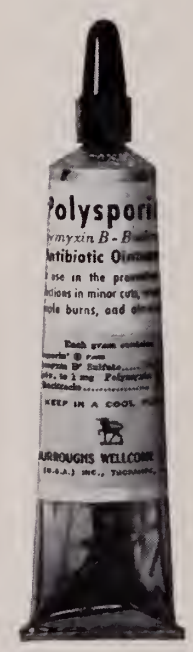
DOWNTOWN LOUISVILLE MANAGEMENT, INC.
1401-A Heyburn Building 587-6982

STAFF PHYSICIANS FOR FULL - TIME APPOINTMENT

VETERANS ADMINISTRATION
HOSPITAL
LEXINGTON, KENTUCKY

THERE ARE OPENINGS for several full-time staff Physicians at this predominately psychiatric hospital with expanding medical, surgical and geriatric services. Salary $9980 to $18,240 depending on qualifications; liberal fringe benefits. Excellent cultural and educational opportunities in community. Visit for personal interview can be arranged at our expense. Moving costs to Lexington will be paid. Write or call Director, V. A. Hospital, Lexington, Kentucky.

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Supplied:** in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

In Memoriam

JOHN G. YOUNG, M.D.
(formerly) Winchester, Ky.
1875 - 1964

John G. Young, M.D., 89, who had practiced in Clark County for 38 years, died April 25 at a New Castle nursing home. Doctor Young, who graduated in 1906 from the Louisville School of Medicine, had practiced in Estill and Montgomery Counties before going to Clark County.

THOMAS JEFFERSON CRUME, M.D.
Owensboro, Ky.
1918 - 1964

Thomas J. Crume, M.D., 46, Owensboro internist, died April 26 of an apparent heart attack. A native of Bardstown and a 1943 graduate of the University of Louisville School of Medicine, Doctor Crume had practiced internal medicine in Owensboro since 1948.

GEORGE LEONARD RICHARDSON, M.D.
Adairville, Ky.
1919 - 1964

George L. Richardson, M.D., 44, Adairville general practitioner, died suddenly April 22 after having been in ill health for several months. A World War II veteran and a 1945 graduate of the University of Louisville School of Medicine, Doctor Richardson had practiced at Beechmont before moving to Adairville.

JAMES G. HUTCHINSON, M.D.
Louisville, Ky.
1878-1964

James G. Hutchinson, M.D., 86, retired general practitioner who had practiced both at Bonnieville and at Louisville, died April 30 in Louisville. Doctor Hutchinson, a veteran of the Spanish American War, graduated in 1904 from the Louisville Medical School. He had retired in 1957.

WILLIAM NOAH JONES, M.D.
Somerset
1882-1964

William Noah Jones, M.D., 81, retired general practitioner, died April 23 after an illness of several months. Doctor Jones, a 1914 graduate of the Lincoln Memorial University Medical Department in Knoxville, practiced in Harlan County until 1947, when he moved his office to Somerset. He was retired from active practice.

U.K. Library Receives Books

The University of Kentucky College of Medicine is one of seven new medical schools across the United States to benefit from the donation of 12,345 volumes of scientific journals and 752 textbooks by the American College of Surgeons.

The University of Kentucky received 2,881 books and journals, which were given by the ACS when its library was changed to an historical collection with emphasis on American surgery. Librarians from the seven schools made the selections for their libraries.

Wholesale Drugs

and

Physicians Supplies

JOHN T. VIE CO., INC.

WH 4-7784 New Albany, Ind.

The Modern Physician



must spend many hours keeping himself informed so that he may better serve his patients and his profession. Today, a doctor refers cases requiring special techniques to those trained in handling them.

Just so, select your jeweler who must have training, experience and an established reputation for honesty and dependability. KENDRICK is such a jeweler, being a REGISTERED JEWELER of the AMERICAN GEM SOCIETY. Call on us at any time for expert advice and assistance in selecting quality gems. This service costs no more.

Kendrick
Jewelers since 1832
MEMBER AMERICAN GEM SOCIETY
619 SO. FOURTH ST. 584-5232



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #24-62. This patient was a 19 year old married white gravida 2 para 1 under the care of a private physician. On May 1, 1961, she was uneventfully delivered of a living female infant weighing 4 lbs 11 oz after 19½ hours of first stage labor. The antepartum course was uneventful. She was admitted to the hospital in labor at 12:45 a.m. on August 7, 1962, contractions having begun at 6:30 a.m.

On examination, the cervix was 2 cm. dilated and the membranes were bulging. Contractions were described as occurring irregularly every 5-10 minutes and lasting 30-40 seconds. The blood pressure was 120/70. The presenting part was floating, and the fetal heart beat was counted at 132 beats per minute. At 6:00 a.m., the dilation of the cervix was still 2 cm, and the fetal heart beat, counted at 128, was described as irregular and weak. The patient complained of severe backache.

At 8:00 a.m., the dilation was 2-3 cm. and the head was at -1. Backache continued. Uterine contractions were noted at 5 minute intervals, lasting 40 seconds. The patient complained continuously. Sedation with 50 mg of Demerol and 1/150 gr of Scopolamine was given. No note was made of the fetal heart beat at this time. At 9:35 a.m., the cervix was still 3 cm. dilated and the head at station 0. The previous sedative doses were repeated.

The patient's physician performed a vaginal examination at 10:00 a.m. He found the cervix to be dilated to 6 cm., and the contractions to be spaced at 2-3 minute intervals, and lasting 40 seconds. The membranes were ruptured artificially. The fetal heart rate was not checked. At 10:35 a.m., another vaginal examination showed the cervix to be 8 cm. dilated. The patient was taken to the delivery room and given saddle block anesthesia. Examination revealed complete dilation of the cervix with a persistent ROP position and no progress in descent of the head despite strong uterine contractions one hour after rupture of the membranes. A low forceps application was made without difficulty, internal rotation completed, and a 7 lb 10½ oz girl delivered in good condition at 11:02 a.m. The placenta was expressed intact at 11:04 a.m.

Immediate examination revealed a high vaginal laceration on the posterior wall extending up to the left vaginal vault. Bleeding was described as coming from a large vein; this was controlled by direct tamponade, and no attempt was made to repair the laceration until additional help was available, when all visible lacerations were sutured and hemostasis apparently obtained. A vaginal pack was inserted "to be safe."

Subsequent observation of the patient suggested that she was having more bleeding than normal, and an obstetrical consultant was called at 1:10 p.m. He removed the vaginal packing and noted that no land marks of the cervix or vaginal fornices could be recognized because of widespread oozing. A figure of eight suture was placed high laterally without slowing the bleeding, so immediate abdominal exploration was undertaken on the delivery table. The patient's condition was so critical that little bleeding was encountered during laparotomy.

There was a hematoma of the left broad ligament extending to the infundibulopelvic ligament, but no free blood in the peritoneal cavity. The uterus was quickly removed and the vagina exposed. During this procedure the patient had stopped breathing, and no pulse could be obtained. An effort was made to insert a needle into the aorta for transfusion, but the vessel had collapsed completely. The cause of death was: postpartum hemorrhage from laceration of the posterior vaginal wall extending into the left broad ligament.

Comments

The Committee classified this as a direct obstetric death with preventable features for which the physician was responsible. There was avoidable delay in securing hemostasis from the vaginal laceration observed following the forceps extraction. Insertion of a vaginal pack at this time simply served to obscure the fact that bleeding was continuing above the level of the highest suture. By the time defini-

tive intervention for control of bleeding from the ruptured uterus was undertaken, the patient's condition was irreversibly critical. Insufficiently prompt intervention for the control of postpartum hemorrhage is the principal cause of death from this potentially serious obstetric complication.

KTS Regional Meet Held at Ky. Dam

Three University of Louisville authorities on pulmonary disease addressed physicians attending the regional meeting of the Kentucky Thoracic Society held at Kentucky Dam Village, Gilbertsville, on April 16. William H. Anderson, M.D., associate professor of medicine, Grover B. Sanders, M.D., assistant clinical professor of medicine, and Donald T. Varga, M.D., instructor in medicine, presented the scientific program.

Ky. Physicians Newly Listed In 'Who's Who in America'

Several Kentucky physicians and members of allied professions were among those recently listed for the first time in the 33rd edition of *Who's Who in America*.

Included in the new listings are the late Everett L. Pirkey, M.D., who at the time of his death last July was chairman of the department of radiology at the University of Louisville School of Medicine; Rudolf J. Noer, M.D., chairman of the department of surgery; and Peter K. Knoefel, M.D., chairman of the department of pharmacology.

Other department heads at U. of L. who are listed are: William M. Christopherson, M.D., department of pathology; Douglas M. Haynes, M.D., department of obstetrics and gynecology; James A. Kennedy, Ph.D., department of microbiology; and John F. Taylor, Ph.D., department of biochemistry. Also included are Harold E. Boyer, D.M.D., assistant dean of the U. of L. School of Dentistry, and Hubert L. Dobbs, administrator of Kentucky Baptist Hospital.

MT. HOLLY
NURSING HOME

A Nursing Home with Hospital Standards



- *24 Hour Personal, Medical and Nursing Care supplemented by Closed Circuit Television.*
- *Balanced and Therapeutic Diets.*
- *Facilities for Orthopedic, Geriatic and Medical Patients.*
- *Leisure time activities.*

MT. HOLLY NURSING HOME

OFF BROWNSBORO ROAD 897 - 1646

RECOGNIZE THIS PATIENT?



"I can't cope any more . . . the kids drive me crazy. I worry about everything . . . feel exhausted all the time."

When you recognize depression and anxiety traceable to an emotionally charged situation with no somatic disorder

—*start the patient on 'Deprol'*

Typical situations in which 'Deprol' is indicated:

marital or other family problems ■ death of a loved one ■ financial worries ■ fear of cancer, heart disease or other life-threatening illness ■ pre- and post-operative apprehensions ■ retirement problems, and many other stressful situations which cause the patient to feel a sense of loss, guilt or unworthiness

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' restores normal sleep, relaxes physical tensions, and improves appetite.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is relatively nontoxic and free of side effects.
5. When depression and anxiety accompany physical illness, 'Deprol' is compatible with drugs used to treat these organic conditions.

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 tablet t.i.d. or q.i.d. May be increased gradually, as needed, to 6 tablets daily. With establishment of relief, may be gradually reduced to maintenance levels. **Supplied:** Light-pink, scored tablets Bottles of 50.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-793

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS — 1963-1964

GEORGE P. ARCHER, Prestonsburg ..... President
DELMAS M. CLARDY, Hopkinsville ..... President-Elect
DAVID M. COX, Louisville ..... Immediate Past President
CARLISLE MORSE, Louisville ..... Vice President (Central)
CARL C. COOPER, Bedford ..... Vice President (Eastern)
JOHN DICKINSON, Glasgow ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, Corbin ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
DOUGLAS E. SCOTT, Lexington ..... Chairman of the Board of Trustees
GABE A. PAYNE, JR., Hopkinsville ..... Vice Chairman of the Board of Trustees

DELEGATES TO THE A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

BOARD OF TRUSTEES

First District ..... O. LEON HIGDON, 2515 Broadway, Paducah 1965
Second District ..... HOWELL J. DAVIS, 330½ Allen Street, Owensboro 1964
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville (serving interim term) 1964
Eighth District ..... DON JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1964
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1964
Eleventh District ..... HUBERT C. JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... CLYDE C. SPARKS, Mayo Arcade, Ashland 1964
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

BUYERS GUIDE

JOURNAL OF THE KSMA BUYERS GUIDE FOR JUNE, 1964

Ames Company 493
A.M.A. Motion Picture Catalog 484

Baker Laboratories 425
Burroughs Wellcome 423-486

Chatham Pharmaceutical, Inc. 483
Coca-Cola Company 426

E. L. Dennis, M.D. 478
Downtown Louisville Management Co. 486

The Keeley Institute 478
Wm. Kendrick Jewelers, Inc. 487

Lederle Laboratories 424-430-431-461-466-467-481
Eli Lilly & Company 432

Medical Protective Company 468
Mt. Holly Nursing Home 489

New Castle Sanitarium 426

Parke, Davis & Company 418
Pharmaceutical Mfg. Assoc. 477

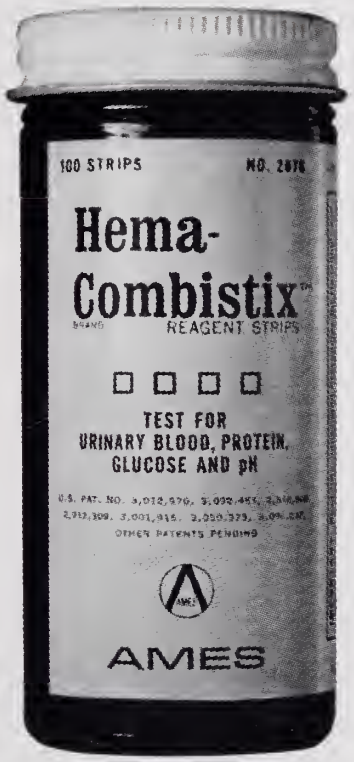
A. H. Robins Company 471-472-473
Roche Laboratories 494

W. B. Saunders Company 419
G. D. Searle & Company 459
Smith Kline & French 427
Southern Optical Company 468

John T. Vie Company 487

V. A. Hospital 486

Wallace Laboratories 429-465-475-485-490-491
Winthrop Laboratories 421





Once you have used **HEMA-COMBISTIX,**™ dip-and-read test for urinary blood, protein, glucose, and pH, it may become a habit to test every patient's urine routinely with this simple, convenient reagent strip. Most of the answers will be "negatives," but an unexpected "positive" may alert you to serious pathology even before related symptoms appear. The test takes only 60 seconds. As basic as the stethoscope...**HEMA-COMBISTIX** is a *good* habit to form. □ Ames Company, Inc., Elkhart, Indiana. 6876-4

AMES
AMES



New from Roche research

Valium®
(diazepam)

for
- —situational, stress-induced tension
- —the psychic tension of the common psychoneuroses
- —emotional tension intensified by concomitant somatic components

also for
- —the muscle spasms of cerebral palsy and athetosis

Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d.

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in dealing with psychotic patients manifesting anxiety and should be avoided when there is reason to believe the patient is psychotic.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.*, convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

How supplied: For oral administration: Valium (diazepam) scored tablets, 2 mg, white, bottles of 50 and 500; 5 mg, yellow, bottles of 50 and 500.

ROCHE LABORATORIES / Division of Hoffmann-La Roche Inc / Nutley, N. J. 07110

JULY 1964 • VOLUME 62 • NUMBER 7

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



LIBRARY
COLLEGE

In This Issue

Epidemiologic Associations of Environmental Factors With Diabetes Mellitus
Christian R. Klimt, M.D., and Martin G. Goldner, M.D. 511

Allergy in Otolaryngology
Jack R. Anderson, M.D. 517

The Allergic Emergency—Aftermath of Modern Therapeutics (Part II)
Joseh H. Shaffer, M.D. 523

Chondromalacia of the Patella
Daniel G. Costigan, M.D., James M. Riley, M.D., and Fred E. Coy, M.D. 527

Complete Contents on Page 498

KSMA Annual Meeting Sept. 29.—Oct. 1
Convention Center, Louisville



pollens in the grass...alas

Kapseals®
Benadryl®
(diphenhydramine hydrochloride)

FOR EFFECTIVE CONTROL OF ALLERGIC SYMPTOMS—*Antihistaminic action* relieves nasal congestion, sneezing, lacrimation, and pruritus. *Antispasmodic action* relieves bronchial spasm. **Precautions:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers, if used with BENADRYL (diphenhydramine hydrochloride), should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENADRYL (diphenhydramine hydrochloride). BENADRYL (diphenhydramine hydrochloride) is supplied in several forms including Kapseals containing 50 mg. 39864

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

279-4

VOLUME 62 • JULY 1964

Issued Monthly Under the Direction of the Board of Trustees

• EDITOR

Som A. Overstreet, M.D.

• ASSOCIATE EDITOR

Walter S. Coe, M.D.

• MANAGING EDITOR

J. P. Sonford

• ASST. MANAGING EDITOR

Ann M. Hentsman

• DEPARTMENTAL EDITORS

Jack L. Chumley, M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscar J. Hayes, Case Discussions
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR

George F. Brockmon, M.D., Chairmon
Willett H. Rush, M.D.
Bloine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Moore, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1967

Edward C. Graves, M.D.
Carl W. Kumpe, M.D.
Marvin A. Lucas, M.D.
Rabert N. McLead, Jr., M.D.
Henry W. Past, M.D.
Clintan R. Patts, M.D.
Oscar Thampsan, M.D.
Gearge I. Uhde, M.D.

Term Expires July 1, 1966

Harald L. Bushey, M.D.
Edward J. Fadell, M.D.
Merle W. Fowler, Jr.. M.D.
Jaseph L. Goldstein, M.D.
Jahn D. Lavett. M.D.
Gearge F. McAuliffe, M.D.
Ralph G. Thomas, M.D.
Eugene Tadd, Jr., M.D.

Term Expires July 1, 1965

McHenry S. Brewer, M.D.
Lewis Dickinson, M.D.
Zygmunt Gierlach, M.D.
Douglas L. Gillim, M.D.
Arthur H. Keeney, M.D.
James B. Stith, M.D.
Chester B. Theiss, M.D.
Kearns R. Thampsan, M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205

Subscription $8.00—single copy .80

Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

Epidemiologic Associations of Environmental Factors With Diabetes Mellitus
Christian R. Klimt, M.D., and Martin G. Goldner, M.D. 511

Allergy in Otolaryngology
Jack R. Anderson, M.D. 517

The Allergic Emergency— Aftermath of Modern Therapeutics (Part II)
Joseph H. Shaffer, M.D. 523

Chondromalacia of the Patella
Daniel G. Costigan, M.D., James M. Riley, M.D., and Fred E. Coy, Jr., M.D. 527

CASE DISCUSSION

Evaluation of the Brain Injured Child
R. D. Brooke Williams, M.D., and Clifford I. Whipple, M.D. 530

SPECIAL ARTICLE

Answers to Your Questions on the Medical Care Program for the Dependents of Uniformed Services Act (P.L. 569) 533

EDITORIAL

Gastric Ulcer 535

ORGANIZATION SECTION

Variety to Keynote 1964 KSMA Annual Meeting Sept. 29-Oct. 1 ..537
Perry County Starts "Pay-All" Blue Shield Plan 538
Jefferson County Disaster Care To Get Plane Crash Test 538
Is It Necessary? The Good Samaritan Proposal for Kentucky 540
U. of L. Names Dr. Keller to Head Psychiatry Department 542
KSMA Woman's Auxiliary Praised for Health Careers Work 542
KSMA Field Service Director Resigns Effective July 1 542
Blue Shield, Blue Cross Set Records in '63 548
Blue Shield Performance Test Started May 18 548
U. of L. Gets $45,000 For Aid in Curriculum Development 548
Battered Child Law to Protect Children from Physicol Abuse 550
Letter to Young Physician Offers Ageless Advice 550

REGULAR FEATURES

President's Page 500
Insurance Page 507
Postgraduate Page 551
In The Books 556
Public Health Page 562

For the "modern Cinderella"

pHisoHex®

enhances any acne treatment



"...No other disease has caused so much feeling of inferiority" as acne.[1] pHisoHex "...is a valuable part of the management...since in addition to its defatting and cleansing properties, it offers an antibacterial action which reduces skin bacterial flora."[2]

In a series of 42 patients, none "...failed to improve," when pHisoHex was added for the wash.[3] In another series of 67, acne lesions "...cleared in a matter of one to two weeks" in 50 per cent with pHisoHex.[4] In another series of 100 patients using pHisoHex and pHisoAc®, 79 showed excellent or good improvement.[2]

The frequent exclusive use of pHisoHex enhances adsorption of its 3% hexachlorophene content to the skin; there it remains as a tenacious film to fight bacteria *between* washings. pHisoHex cleans thoroughly—is nonalkaline, hypoallergenic and "kind" to the skin. Three to four washings a day are needed for constant degerming of skin, faster and better results.

pHisoAc Cream dries, peels and masks lesions—helps prevent comedones, pustules and scarring. Contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent and hexachlorophene 0.3 per cent.

How supplied: pHisoHex is available in unbreakable squeeze bottles of 5 oz. and 1 pint, in unbreakable plastic bottles of 1 gallon and in combination package with pHisoAc Cream.

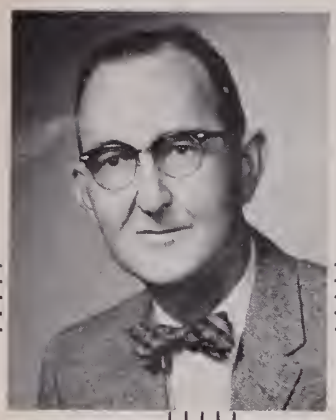
References: 1. Szymanski, F. J.: *Indust. Med.* 30:498, Nov., 1961. **2.** Wexler, Louis: *Clin. Med.* 70:404, Feb., 1963. **3.** Hodges, F. T.: *GP* 14:86, Nov., 1956. **4.** McLean, I. E. D.; Graham, K. T., and East, M. O.: *Practitioner* 189:82, July, 1962.

Winthrop

Winthrop Laboratories, New York, N. Y.



(1888-M)



MESSAGE FROM THE PRESIDENT

Tobacco

SOME Kentucky physicians, when presented the problems stated by the Surgeon General's report, *Smoking And Health,* find themselves in a position comparable to that of the great Galileo when in 1633 he was forced to recant his views on the Copernican system of astronomy and to testify before the Inquisition that the earth was motionless and the sun revolved around the earth. This saved Galileo from torture and death in the Inquisition. Years after Galileo, his teaching on the Copernican system gradually became accepted as fact and finally in 1835 the Church removed his works from the Index of Prohibited Books.

Many of the Kentucky physician's patients earn their livelihood either directly or indirectly from tobacco farming or cigarette manufacture and sales. These people feel they owe allegiance to tobacco and tend to resent any criticism of smoking. Many other patients are confirmed cigarette smokers who are convinced that the pleasure derived from smoking outweighs any danger to their health.

This situation calls for sympathy and tact on the part of the physician. Brash and frank statements concerning the harmful effects of cigarette smoking will offend some patients or reduce their respect for the doctor. Some will infer that the doctor says they smoke because they are stupid. So, the present generation of smokers should be given the knowledge of harmful effects of tobacco with caution.

Our best hope of eliminating the harmful effects of tobacco is to teach the young children and the coming generations not to use tobacco. We can then hope that after fifty years the cigarette will become as obsolete as the seventeenth century snuff-box. We can also expect our farmer friends to gradually change to another money crop without serious damage to their economy.

JOHN DICKINSON, M.D.
KSMA Vice President (Western)

**This is the last of a series of four guest articles written at the request of the president of the KSMA by the president of the Woman's Auxiliary and the three vice-presidents of KSMA.*

HOW TO WIN FRIENDS...

little



New
Orange Flavored
Bayer Aspirin for Children
is sweet
all the way through,
so children
take it readily.
The GRIP-TIGHT CAP
on the bottle
helps keep them
from taking it
on their own.

Bottles of 50 tablets
(1¼ grains each)

NOW!
NEW ORANGE FLAVOR!

We will be pleased to send
professional samples on request.
THE BAYER COMPANY
Division of Sterling Drug Inc. Dept. 112
1450 Broadway, New York 18, N.Y.

RECOGNIZE THIS PATIENT?



"I don't sleep well...I dream a lot... wake up tired and irritable. I don't have any appetite . . . I'll never be cured."

When you recognize depression and anxiety related to an organic condition
—*add 'Deprol' to your therapy*

Typical organic conditions in which 'Deprol' helps control related depression and anxiety:

cardiovascular disorders ■ arthritis ■ cancer ■ menopause ■ alcoholism ■ obesity ■ asthma, hay fever and related allergies ■ chronic infectious diseases ■ dermatoses ■ G.I. disorders, and many other debilitating or life-threatening illnesses

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' relaxes physical tensions, restores normal sleep and revives interest in food.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is compatible with drugs used to treat co-existing organic conditions.
5. 'Deprol' is relatively nontoxic and free of side effects.

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 tablet t.i.d. or q.i.d. May be increased gradually, as needed, to 6 tablets daily. With establishment of relief, may be gradually reduced to maintenance levels. **Supplied:** Light-pink, scored tablets Bottles of 50.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-2022



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective **GERIATRIC** antiarthritic with

REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate-SF

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe
PABALATE-SODIUM FREE

"... their feelings of anxiety seemed to contribute to the urge to overindulge in cake, candy, and other rich food."[1]



ESKATROL® Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate

SPANSULE®

brand of sustained release capsules

controls appetite all day long with a single morning dose

relieves the emotional stress that causes overeating

Brief Summary of Principal Side Effects and Cautions

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory

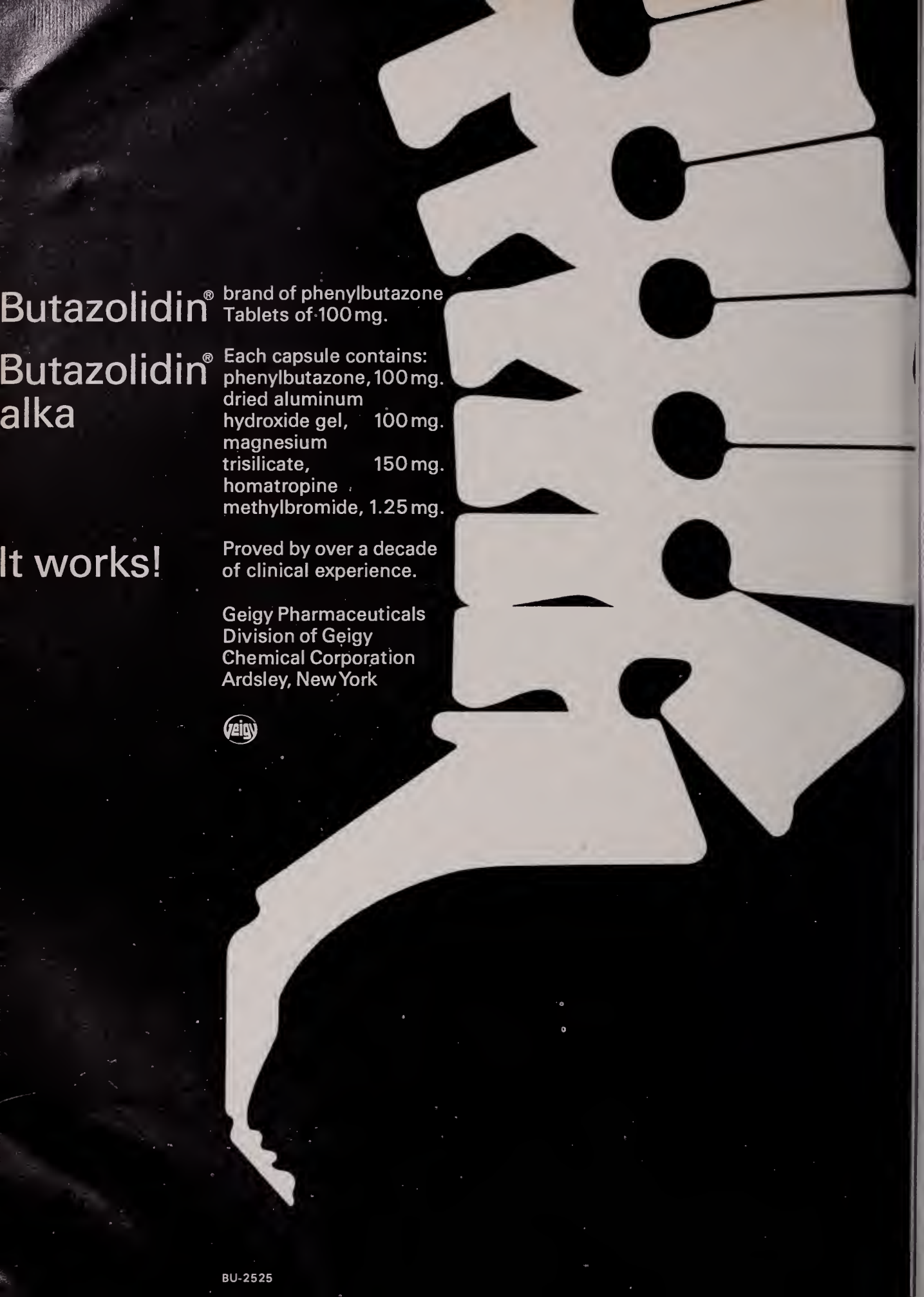
Cautions: 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

Before prescribing, see SK&F Product Prescribing Information.

Supplied: Bottles of 50 capsules.

1. Viglione, J.P.: Clin. Med. *69*:1157 (May) 1962.

Smith Kline & French Laboratories SK&F


Butazolidin® brand of phenylbutazone
Tablets of 100 mg.
Butazolidin® alka
Each capsule contains:
phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.
It works!
Proved by over a decade of clinical experience.
Geigy Pharmaceuticals
Division of Geigy
Chemical Corporation
Ardsley, New York
Geigy
BU-2525



THE INSURANCE PAGE



Information Updated on the Dependents of Uniformed Services Act*

OF major interest to Kentucky physicians is the Dependents of Uniformed Services Act (P.L. 569), which provides certain medical services to the dependents of active members of the Armed Forces. This is the true Medicare program and bears no relation to the proposed federal legislation to provide medical care to the aging through Social Security.

In order to provide KSMA members with the latest information pertinent to this program, a review of its history and provisions are presented below.

I. Enactment of Public Law 569, 84th Congress, which became effective 7 December 1956, was the culmination of efforts by the Uniformed Services to obtain a comprehensive statutory authority providing medical and dental treatment, at Government expense, for eligible dependents of their members. For the first time, dependents could obtain medical care and certain dental care from civilian sources at Government expense, as well as from Uniformed Services medical and dental facilities. Heretofore, treatment had been available *only* in Uniformed Services medical and dental facilities and, then, only if space and staff were available.

II. Before these benefits could be provided in Kentucky for military dependents, it was necessary for the Kentucky State Medical Association to negotiate with the U.S. Government on allowances to be adopted for covered professional services under the Act. This was accomplished, and Blue Shield was named fiscal agent for the Kentucky State Medical Association.

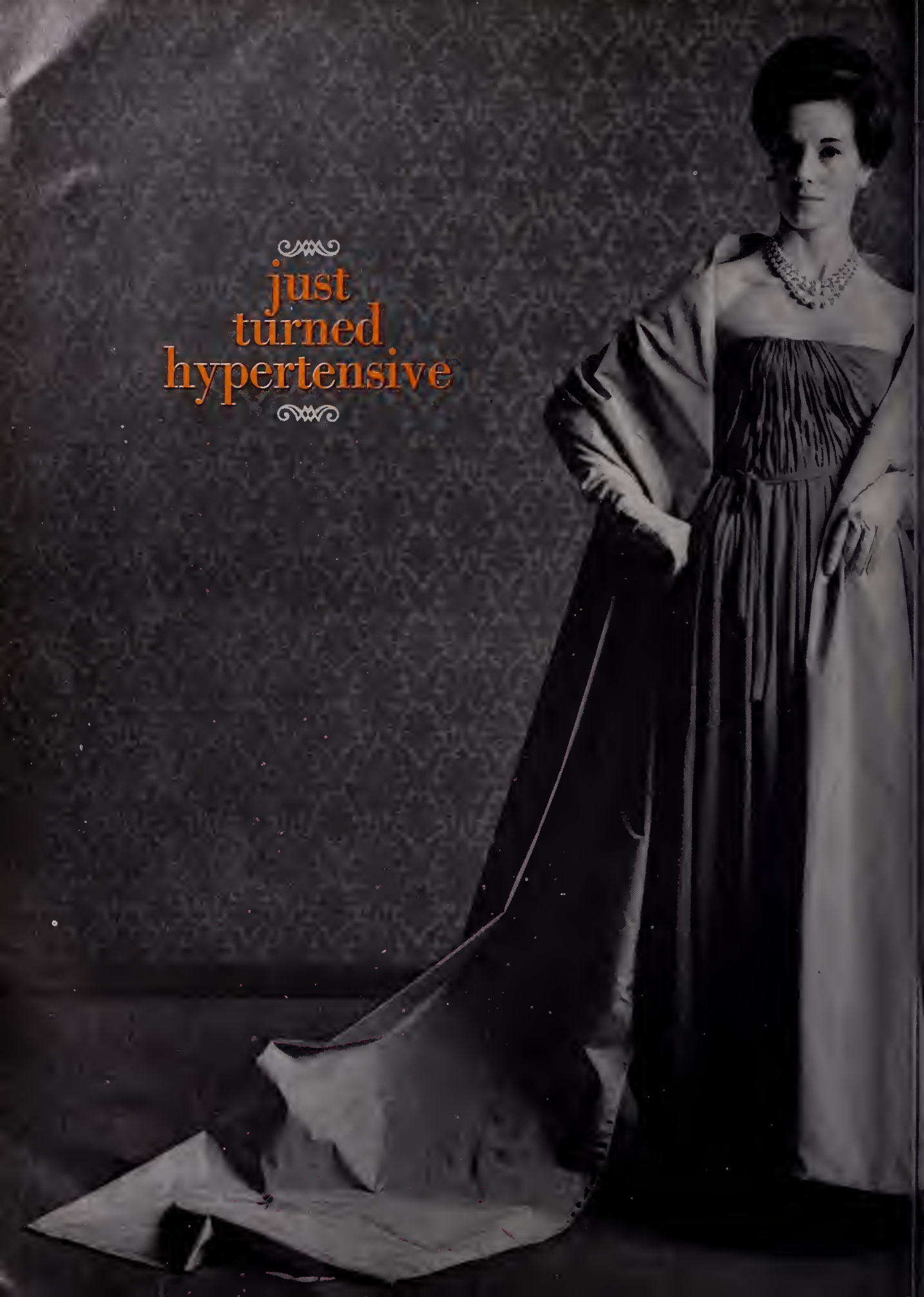
III. Participation by physicians and dentists in the Medicare Program is voluntary; physicians may refuse to accept a Medicare patient without stating a reason therefor.

IV. When a physician or dentist accepts an eligible dependent as a Medicare patient, he agrees that payment will be made from public funds, and that such payment will constitute PAYMENT IN FULL for those services covered by the Program. There is one exception: When the patient is required to pay the first $15 of the attending physician's or dentist's authorized charges, the Government pays the balance. (If all the authorized care provided in a single case is done on an out-patient basis, the patient must pay the first $15 of the physician's or dentist's authorized charges.) However, the sum of these payments constitutes payment in full, as above. In short, once payment has been effected as described, neither the Government nor the patient has further financial liability for the same services.

V. Except in "Special Report" cases, physicians receive the aggregate of their charges for authorized care, or the aggregate of the appropriate maximum allowances, whichever sum is less. All dentists' claims are processed under the "Special Report" provision.

When participating in the Program, physicians and dentists are expected not to bill in excess of their usual charges, keeping in mind the financial status of Medicare patients. The AVERAGE INCOME OF SERVICEMEN WHOSE DEPENDENTS RECEIVE CARE UNDER THE PROGRAM IS ABOUT $4,500.

*(NOTE: Questions and Answers on this Act are to be found on page 533 of this issue of the Journal.)


just
turned
hypertensive

a 15 mm. Hg. drop in diastolic pressure would also suit her very well

for suitably gradual, physiologic hypotensive treatment

HYDROMOX®

QUINETHAZONE·TABLETS

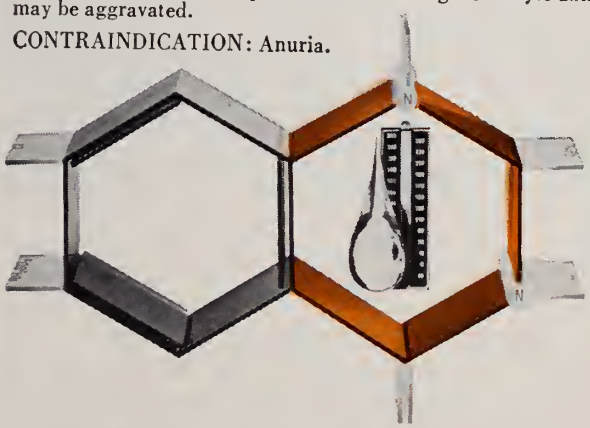
antihypertensive diuretic

HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg.,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.



1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

Lederle

LEDERLE LABORATORIES,
A Division of AMERICAN CYANAMID COMPANY,
Pearl River, New York

6278-4



Putting the cap on a bottle sounds simple. Just make it tight enough to keep the contents in, prevent leakage, and protect the product; loose enough to be opened with ease. However, that isn't quite as simple as it sounds. ■ At Eli Lilly and Company, there are exact-tightness specifications for the cap of every bottle. Capping machines are carefully adjusted to apply just the right amount of torque (or twist) to tighten the caps. Then the tightness of the caps is double-checked . . . just to be sure. ■ That's where the torque tester comes in. At least once every fifteen minutes, five bottles are tested as they come out of the capping machine. They are placed on the torque tester, and the twist on the caps is measured . . . just one more of the many controls that add immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

400654

The JOURNAL of the
Kentucky State Medical Association

Issued Monthly Under the Direction of the Board of Trustees

VOLUME 62 JULY, 1964 No. 7

Epidemiologic Associations of Environmental Factors with Diabetes Mellitus†

Christian R. Klimt, M.D., Dr. P. H.* and Martin G. Goldner, M.D., F.A.C.P.**
Baltimore, Md.

Diabetes has many associations in nature, some apparent, some possibly real. The most consistent one is with a diet low in fat and high in starches.

Introduction

DIABETES mellitus is a syndrome for which the cause in the great majority of cases cannot be ascertained. It is therefore necessary and profitable to study critically associations of the disease as they are found in defined populations, so that from them a working hypothesis of causation and possibly prevention can be derived. The natural history of the disease, incidence, prevalence and mortality and relationships to environmental factors in contrast to genetic ones are the subject of this presentation.

The sources of information for such a study vary all the way from clinical investigations, to diabetes detection drives, cross-sectional population and sample surveys—either by interview or by actual examination—or under certain conditions from a perusal of special food ration cards, to group, regional and national mortality experiences over time. Each of these sources has its special qualities and its manifold shortcomings, which need to be taken into account.

Among the unlimited number of possibly important environmental factors, a few have been selected for discussion, because suggestive evidence of association with diabetes has been reported in the past and because pertinent reference material has been found in the literature. Every environmental influence acts upon the individual and the number of factors shared diminishes with the size and cohesiveness of groups of individuals. The larger a group becomes the more heterogeneous its enviroment will become and, while numbers increase precision, the factors under study become more diffuse and associations, even if strong, become increasingly difficult to discern and to interpret correctly.

Many of the environmental factors are interrelated and if associations are found, it is often impossible to state which are primary, which secondary and which ones spurious.

Age, sex, obesity, parity,—diet: quality, quantity and proportions of principal nutrients, —occupation and degree of physical activity— historical and geographical influences are environmental correlates of diabetes, while familial

† *Presented at the September 26 meeting of the Kentucky Association of Public Health Physicians during the 1963 Annual Meeting of the Kentucky State Medical Association at Lexington, Ky.*

* *Director, division of Epidemiology and Biostatistics, University of Maryland School of Medicine, Baltimore.*

** *Director of Medicine, State University of New York Downstate Medical Center, Brooklyn, N. Y.*

Table 1.

Average Mortality between 1952 and 1958 from Diabetes Mellitus by Sex, Selected Countries and for Two Broad Age groups in Percent of Mortality Experienced by White Women in U.S.A., aged 40 and over.

(Age standardized to equal weight for 18 five year age groups)

COUNTRY	FEMALE		MALE	
	40 yrs +	under 40 yrs	40 yrs. +	under 40 yrs
U.S.A. (White)	100.0	1.1	75.7	1.3
(non-white)	98.8	2.2	57.3	2.0
England and Wales	41.1	0.5	29.5	0.6
Norway	38.5	1.3	29.0	1.6
Australia	95.8	0.6	63.5	0.5
Ceylon	40.9	1.0	79.4	1.2
Israel (Jewish population)	39.7	..	36.8	..
Japan	13.5	0.5	15.9	0.3

Source of basic data: Annual Epidemiological and Vital Statistics, 1952 to 1958, World Health Organization, Geneva, Switzerland.

and racial aggregation could be due to either or both environmental and genetic influences.

The analysis is confounded by differences in medical care, medical customs and preferences, diagnostic standards and availability of laboratory tests as well as registration practices of vital events. These factors change over time as well as by country and often even between occupational, racial, religious, sex and age subgroups.

Many associations may consequently be man-made artifacts but are not readily apparent as such.

Obesity, Parity, Marital Status and Sex

The trends of diabetes incidence, prevalence and mortality by sex have been studied and commented upon by many authors in the past[1, 2, 3] but the subject because of its complexity deserves a critical review. In the beginning of this century mortality for the two sexes was nearly the same in the United States, while in Western Europe males predominated[4-9]. Male diabetes mortality in the United States, after eliminating the effect of ageing of the population, has essentially remained the same throughout the first half of this century until 1949 when a break in registration practices made further comparisons difficult[10]. Female mortality on the other hand showed a consistent, linear upward trend over the same period. Female preponderance has become a regular feature of mortality statistics in the great majority of nations. Exceptions are Japan and Ceylon, where male excess mortality from diabetes has remained. (Table 1). Sex differences are far less regular at ages under 40 years and often those very countries who have an overall female preponderance, show a male excess mortality from diabetes (Table 2). If we could apply the findings of Lombard and Joslin[11] to the diabetes mortality experience of the United States as a whole, the observed sex difference would virtually disappear*. On the other hand, countries with a male preponderance may also be those where males enjoy a relatively more important place in society and consequently greater attention medically and otherwise. A similar argument could be used to explain the historical trend in Western nations from male to female preponderance. Thus it is entirely possible that differences in diabetes mortality by sex, be they in either direction, are artifacts and not part of the natural history of the disease.

In population-based prevalence surveys using various techniques and, because of their organizational requirements, largely confined to countries of the West, again female preponderance has been universally observed. While in the Oxford, Massachusetts study [12] the sex difference after age adjustment was only six percent, the two U. S. National Health Surveys (Fig. 1) [13, 15] both showed a substantial female excess. The former was based on urine and blood sugar

* *Lombard and Joslin have ascertained the registered cause of death for 1,000 known diabetics, i.e. whether diabetes was mentioned as leading cause, as secondary cause or not at all on the death certificate. They found significant differences in accuracy by age and sex. In only 33% was diabetes registered as cause of death and in 23% diabetes was not mentioned at all.*

Table 2.

Average Mortality between 1952 and 1958 from Diabetes Mellitus by Sex, for Selected Countries for Ages under 40 in Percent of Mortality Experienced by Non-white Women in U.S.A., Aged under 40.

(Age standardized to equal weight for 8 five year age groups)

COUNTRY	FEMALE	MALE
U.S.A. (Non-white)	100.0	91.1
(White)	48.2	58.0
England and Wales	23.7	25.0
Norway	58.1	69.8
Australia	26.7	23.3
Ceylon	44.1	51.5
Japan	22.8	15.6

Source of basic data: Annual Epidemiological and Vital Statistics, 1952 to 1958, World Health Organization, Geneva, Switzerland.

screening of the majority of the population of a small town, while the latter was based on questioning of a nationwide sample. The Oxford survey revealed a greater number of previously unknown cases among males. The female excess essentially appears only after their reproductive period has come to an end and the hormonal imbalance caused by the onset of the menopause was thought to be the cause. This theory remains difficult to maintain in view of the fact, that female excess mortality is essentially restricted to married, divorced and widowed and in turn parous women [16, 17, 18]. Women on the average are more obese than men and married women more so than single women.

It has been found repeatedly that the principal diagnostic test for diabetes, the glucose tolerance test, is correlated to obesity within age and sex sub-groups [19 - 23]. As the same critical values are used for everyone, the likelihood of a "chemical" diagnosis of diabetes would appear to be enhanced in the post-menopausal, obese, parous, married, divorced or widowed woman. This does not necessarily mean that she has the disease diabetes more frequently than her single, slimmer, nulliparous, post-menopausal fellow woman or indeed her contemporary men. It may be on the other hand, that by virtue of her vocationally changed constitution, she tends more frequently to overtax her insulin reserves and develop clinical diabetes. In either case it is clear that a chain of environmentally controlled factors are operating and that these, in contradistinction to genetic ones, are largely under human control though not generally avoidable.

Unfortunately, good mortality data by degree of overweight are lacking for females. In men

AGEGROUP AND SEX SPECIFIC PREVALENCE OF DIABETES MELLITUS FROM U.S. NATIONAL HEALTH SAMPLE SURVEYS, 1936 to 1937 AND 1957 to 1959

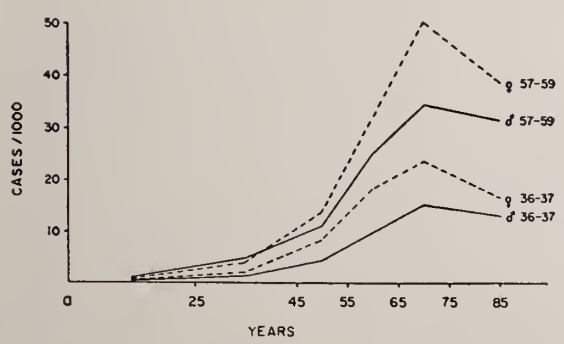
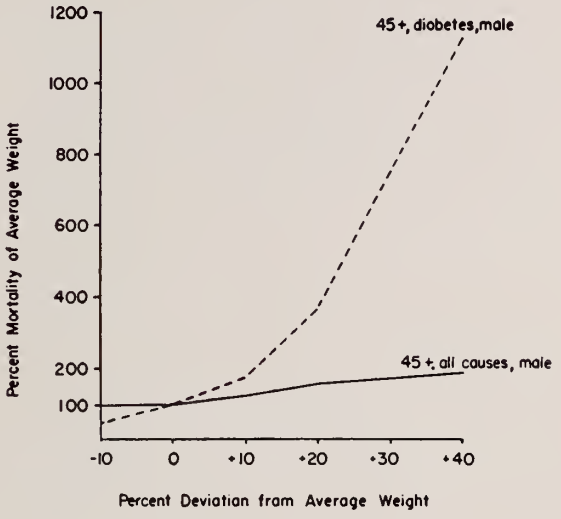


Figure 1.

RISK of DYING from ALL CAUSES and from DIABETES RELATIVE to DEGREE of DEPARTURE from AVERAGE WEIGHT for HEIGHT and AGEGROUP at TIME of PHYSICAL EXAMINATION for LIFE INSURANCE.

(Males, white, urban, low risk group, medium to upper income in Midwest, East and South of USA between 1887 and 1908, Aged 45 years and over at time of death)



Source: L.I. Dublin, THE INFLUENCE of WEIGHT on CERTAIN CAUSES of DEATH, Human Biology, 2:159, 1930

Figure 2.

the excess risk of dying from—or with—diabetes in relation to his departure from average weight for his height, sex and age group and relative to the risk of dying from all causes is dramatic (Fig. 2)[18]. We must realize however that this effect appears to be restricted to men dying after age 45 and that Dublins classical paper does not take age at death for the various weight groups into account. Diabetics dying under the age of 45 show very little increase in mortality risk with increasing overweight.

Geographical, Racial and Dietary Factors

The evaluation of geographic and racial factors in the epidemiology of diabetes depends almost exclusively on mortality statistics. Many of their shortcomings are well recognized[8], but often defy attempts at quantitative correction. Even if one adjusts the data for differences in age and sex composition, one is still confronted with differences in medical care, diagnostic standards, in the intensity of searching for cases, in accuracy of registration and variability of vital statistical priority rulings. Beyond these man-made factors, one has to consider the true phenomenon of competing risks of death. Traffic and industrial hazards afflict one type of

society, while pestilentious diseases are more important in others. Tuberculosis is thought to be more frequent in diabetes than in comparable groups of the general population [24-26], and it may be that tuberculosis is diagnosed and recorded on the death certificate and not diabetes. Thus it becomes clear that inferences from mortality statistics, if they can be made validly at all, have to be made with great caution.

Even age adjusted mortality rates for diabetes differ widely among nations. The United States are leading the field, followed by European nations and with Japan being lowest among the large countries. Within countries great regional differences exist, although they are not of the magnitude of the national differences. In the U. S. A., in addition to mortality information, information from interview sample surveys is available. Both agree that diabetes is most commonly recognized in the Northeast, followed by the North Central, the Southern and Western parts of the country[4, 14]. Regional differences have also been documented for England[27]. The fact deserves retention that prevalence is highest in rural farm areas and lowest in rural non-farm areas. Urban districts hold an intermediate position. Regional differences are in general of greater magnitude than are the ones between farm and non-farm areas[28].

While it can by no means be considered as established that true differences in diabetes prevalence and mortality exist, the recorded differences are at least compatible with the hypothesis advanced by Himsworth [29, 30] and supported by others[31, 32]. High fat and low carbohydrate diets would appear to be associated with high diabetes rates. By the same token support could also be found for similar associations with animal sources of fat versus vegetable ones and saturated versus unsaturated fats. Caloric intake and amounts of protein consumed vary much less between countries and over time and do not appear to be correlated with diabetes. On the other hand a similar if less consistent correlation can be established between the amount of refined sugar consumed and the diabetes rate, a theory which also has its proponents. [33]

It has been a long standing item of medical belief, that the Jewish race is unusually prone to develop diabetes [34, 35]. One of the sources for this conclusion was a study made in New York City [36] where diabetes mortality by racial groups were compared. Differences in medical consciousness and availability of medical care could have produced the racial differences observed, or alternatively differences in diet and, least probable of all, in genetic disposition might be responsible. Mortality as well as sample prevalence data from Israel [37, 38] seem to indicate that diabetes in Jews living under Israeli conditions is certainly no higher than among Caucasian nations. Cohen's diabetes prevalence study[39] has brought other interesting facts to light. Eastern Jews appear to have less diabetes than those of Western origin. Yemenite Jews, with their low fat, high carbohydrate diets, have a particularly low diabetes rate, which is increasing in the younger generation, whose way of life including their diet tends to become more like that of the rest of the country. The Yemenite minority would also fit other associative patterns with a low intake of refined carbohydrate, increasing by generation and greater affluence, of little obesity and of a patriarchal family structure and corresponding greater frequency of diabetes in males in contrast to the experience of the majority of Israelis.

Time Trends and Occupational Patterns

Mortality from or with diabetes, age adjusted to the distribution of the United States population in 1940, has more than doubled in the U.S. between 1900 and 1948 (from 12 to 28 per 100,000). (Fig. 3) Increases in middle aged females, and in particular non-white ones, were responsible for this rise in the diabetes mortality rate. The trend for persons under 45 years of age was stable up until the advent of insulin in 1922 when a decline began. Minor fluctuations can be ascribed to the selective removal of healthy young adult males to the armed forces overseas during the late phases of World Wars I and II. A decrease in diabetes mortality in 1918 and 1919 in all age groups is likely to be due to the large mortality from pandemic influenza, which as a cause of death took priority. The mortality trend in persons over 45 years does not appear to be influenced by the advent of insulin. Mortality increases over time and so does the rate of increase. The older the age group concerned, the steeper is the upward movement. A break in the upward trend for older persons and an acceleration of the down-

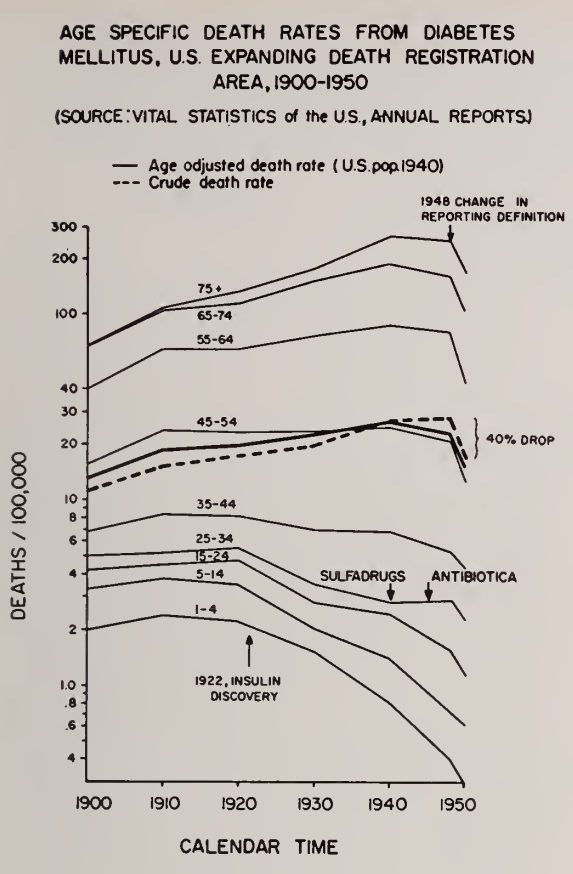


Figure 3.

ward one for younger ones coincides with the advent of sulfa drugs and later of the antibiotics. These drugs have presumably checked the above average risk of diabetics to die from pneumonia and other bacterial infections and thus some of the diabetics deaths have been selectively deferred to a later period and higher age bracket.

Since the introduction of the VIth revision of the International List of Causes of Death, which in the U. S. took place in 1949, time trends are different for different countries and different for the two racial groups in the United States. In the U. S. A. white male rates have stayed stable, while white female rates have declined; non-white male rates have increased and non-white female rates have surpassed the white female rates since 1956 and rates for England and Wales for either sex have changed but little, and no trend is discernible in Australia and Ceylon. In Norway rates for both sexes are on the increase as are those for Japan. Israel shows a consistent decline in both sexes. The new registration practices have on the average reduced diabetes mortality by 40% in the U. S., as the rulings of priority for diabetes of the Vth and preceeding revisions have been superseded by a freedom of the physician—or nonmedical death certifier in some countries—to determine the underlying cause of death. In consequence there is not only a break of continuity in death registration practices between the Vth and VIth revisions, which significantly affects diabetes mortality, but instead for definite if artificial priority rulings, the physician's judgment is substituted. It need not be stressed that this may vary with time and be different among nations.

Diabetes mortality has temporarily declined in all countries involved in war, the decline seemingly coinciding with the beginning of food rationing and in proportion to the severity of restrictions. Wars cause qualitative changes of diet, substitution of starches for fat and rationing of sugar while, at least in the beginning, pre-war caloric levels are maintained[40, 41].

Diabetes prevalence surveys under comparable conditions in the same populations are but rarely available. The two U. S. National Health Surveys in 1936 and 1937 and again 1957 to 1959 show age group for age group and within those for every sex group gains in diabetes prevalence averaging 100 percent (Fig. 1). As one is dealing with interview data, the results of case finding drives, education of the public as well as of the medical profession and possibly the use of diagnostic tests with greater sensitivity will all have contributed to the results. Over the same time period the U. S. national diet has also systematically changed[42] and the trend of substitution of fats for carbohydrates has continued. While in the U. S. well over 45% of all calories come from fat, only 12% are obtained from this source in Japan.

Standard mortality ratios* from England for the period 1949 to 1953 for 18 ocupational groups show above average ratios in the white collar, clerical, predominantly sedentary occupations of men and below average ratios for the manually employed [43].

** SMR—Observed deaths in occupation and sex group in persons aged 20 to 64 over expected deaths in occupation and sex group if rates for all employed persons of same sex and age group during same period in same areas prevailed.*

Summary

The possible effects of environmental factors on diabetes morbidity and mortality have been critically discussed and doubts raised as to the validity of many of the accepted associations. Alternatively it has been pointed out that the apparent associations, while not established beyond doubt, do fit a hypothesis of causation by dietary fat or alternatively protection by dietary starches.

References

1) Harris, H. & McArthur, Norma, *Changes in Sex Incidence of Diabetes Mellitus (1912-1947)* Annals of Eugenics, 16:109-118, 1951.

2) Pyke, D. A., *The Incidence of Diabetes and its Preponderance among Women.* Acta genet., Basel, 7:91-96, 1957.

3) Spiegelman, M. and Marks, H. H., *Age and Sex Variations in the Prevalence and Onset of Diabetes Mellitus.* J.A.P.H.A., 36:26-33, 1946.

4) National Office of Vital Statistics (U.S.A.), Vol. 39, No. 7, 1956, Vol. 43, No. 12, 1956.

5) Stocks, P., *Diabetes Mortality in 1861-1942 and Some of the Factors Affecting it.* J. Hyg. (Cambridge), 43:242-247, 1954.

6) Rooth, Goesta, *The Mortality in Diabetes Mellitus in Some European Countries 1935-1949.* Acte Medica Scand., 149:65-74, 1954.

7) Dublin, L. I. and Marks, H. H., *Mortality from Diabetes Throughout World; Characteristics and Trends. Diabetes,* L:205-217, 1952.

8) World Health Organization, *Causes of Death. Diabetes Mellitus. A Critical Note on Mortality Statistics.* Epidemiological and Vital Statistics Report, 8:467-512, 1955.

9) *Is Diabetes Mortality Increasing?* U.S. Pub. Health Rep., 63:1334-39, 1949.

10) Marks, H. H., *Diabetes and the Revised International List of Causes of Death.* Proc. Am. Diabetes Assoc., 9:347-361, 1949.

11) Lombard, H. L. and Joslin, E. P., *Underlying Causes of Death of 1,000 Patients with Diabetes,* New England J. M. 259 (19):924-926, 1958.

12) Wilkerson, H. L. C. & Krall, L. P., *Diabetes in a New England Town.* J.A.M.A., 152:1-21, 1953.

13) U. S. Dept. Health Education and Welfare, *Diabetes Reported in Interviews.* United States July 1957-June 1959, Public Health Service Publication No. 584-B21, 1960.

14) U. S. Public Health Service, Bulletin No. 6, 1938. *The Magnitude of the Chronic Disease Problem in the United States: National Health Survey,* 1935-36.

15) Perrott, G. St. J., Tibbitts, C., and Britten, R. H. *The National Health Survey—Scope and Method,* Pub. Health Rep., 54:1663, 1939.

16) Mosenthal, H. O. and Bolduan, C., Diabetes Mellitus—*Problems of Present-day Treatment.* Am. J. Med. Sc., 186:605-621, 1933.

17) Pyke, D. A. and Camb, M. B. *Parity and the Incidence of Diabetes.* Lancet 1:818-820, 1956.

18) Dublin, L. 1., *The Influence of Weight on Certain Causes of Death,* Human Biology, 2:159, 1930.

19) Himsworth, H. P., *The Dietetic Factor Determining the Glucose Tolerance and Sensitivity to Insulin of Healthy Men.* Clinical Science, 2:67-94, 1935.

20) Aldersberg, David., *Obesity, Fat Metabolism and Diabetes,* 7:236-242, 1958.

21) Klimt, C. R. Beard, J. H. Meinert, C. L., Silverman, C., Tobler, A. B., and Wolff, F. C. *Familial Aggregation of Prediabetes,* Proceedings 1Vth Congress, International Diabetes Federation, Vol. 1, 279-282, 1961.

22) Embleton, D., *Glucose Tolerance Curves in 500 Obese Cases,* Brit. M. J., 2:739-740, 1938.

23) Ogilvie, R. F., *Sugar Tolerance in Obese Subjects: A Review of 65 Cases,* Quart. J. Med., 4:345-358, 1935.

24) Nichols, G. P., *Diabetes among Young Tuberculosis Patients. A Review of the Association of the Two Diseases,* Am. Rev. Tubc., 76:1016-1030, 1957.

25) Silver, H. and Oscarsson, P. N., *Incidence and Coincidence of Diabetes Mellitus and Pulmonary Tuberculosis in a Swedish County.* Acta Med. Scand., 61:1-48, 1958.

26) Kramer, L. I. and Lawson, H. A., *Incidence of Tuberculosis in Diabetes,* Ann. Int. Med. 6:1426-1433, 1933.

27) Hargreaves, E. R., *The Epidemiology of Diabetes Mellitus,* Public Health, London, 71:362-370, 1958.

28) U. S. Dept. of Health Education and Welfare. Health Statistics from U. S. National Health Survey. Selected Health Characteristics by Area, Geographic Regions and Urban-Rural Residence, P. H. S. Publication No. 584-C5, 1961.

29) Himsworth, H. P. and Marshall, E. M. *The Diet of Diabetics Prior to the Onset of the Disease,* Clin. Science 2:95-115, 1935.

30) Himsworth, H. P., *Diet and the Incidence of Diabetes Mellitus,* Clinical Science, 2:117-148, 1935-1936.

31) Pyke, D. A., *Aetiological Factors in Diabetes,* Postgraduate Med. J. 35:261-265, 1959.

32) Young, F. G., *The Endocrine Approach to the Problem of Diabetes,* Banting Memorial Lecture 1950, Proc. Am. Diab. Assoc. 10:11-24, 1950. Reference to Page 18.

33) Dohan, F. C. and Lukens, F. D. W., *Experimental Diabetes Produced by the Administration of Glucose,* Endocrinology 42:244-262, 1948.

34) Johnson, H. J., *Comparison of Incidence of Glycosuria Among Jews and Non-Jews.* Proceedings of the Life Extension Examiners. 1:42, 1939.

35) Morrison, H. A., *A Statistical Study of the Mortality from Diabetes Mellitus in Boston from 1895 to 1913 with Special Reference to its Occurrence among Jews.* Boston M. & Sc. J. 175:54, 1916.

36) Bolduan, C., and Weiner, L. *Causes of Death Among Jews in New York City.* New Eng. J. Med., 208:407-416, 1933.

38) Cohen, A. M., *Prevalence of Diabetes among Different Ethnic Jewish Groups in Israel.* Metabolism, 10:50-57, 1961.

39) Cohen, A. M., Bavly, Sarah, Poznanski, Rachel. *Change of Diet of Yemenite Jews in Relation to Diabetes and Ischaemic Heart-Disease,* Lancet, Dec. 23, 1961, pp 1399-1401.

40) Gottstein, von A. and Umber, F., *Diabetes and Krieg* (Diabetes and War), Deutsche Med. Wschr., 43:1309-1311, 1916.

41) Goto, Y., Nakayama, Y., and Yagi, T. *Influence of the World War II Food Shortage on the Incidence of Diabetes Mellitus in Japan,* Diabetes, 7:133-135, 1958.

42) Personal communication, Jacob E. Bearman, Ph.D., Professor of Biostatistics, University of Minnesota.

43) The Registrar General's Decennial Supplement, England and Wales, 1951. Occupational Mortality, Part II, Vol. 1, Commentary. Her Majesty's Stationary Office, 1958.

Mark Your Calendar Now

for the

1964 KSMA Annual Meeting

September 29-October 1

Convention Center — Louisville, Ky.

Allergy in Otolaryngology†

JACK R. ANDERSON, M.D.*

New Orleans, La.

The author surveys some of the important factors concerning the manifestations of allergy seen frequently by the otolaryngologist. Various methods of testing and treatment are discussed.

MOST otolaryngologists will agree that allergy is the leading cause of chronic nasal disorders. But this does not begin to tell the story; Table 1 is a compilation of the manifestations of allergy seen frequently in the practice of Otolaryngology.

Because few residencies provide training in allergy, most otolaryngologists can offer patients little more than palliative treatment such as might be used by any alert general practitioner. A quotation from a paper by J. Harvey Black, M.D.[1] is just as *apropos* today as it was in 1950:

> "The young doctor who is just beginning his practice is usually quite surprised to learn that conditions which he seldom saw and treated lightly in the hospital now are rather plentiful and require more help than he may be prepared to give. Unfortunately for the teaching of young men, the common allergic conditions do not often require hospitalization. For this reason, the teachers of medicine themselves are not fully aware of the frequency and the importance of the conditions in private practice, and teaching suffers on that account."

This unfortunate situation cries for correction because the practice of otolaryngologic allergy can be one of the most scientifically fascinating and emotionally rewarding facets of our specialty. Besides, as we always point out when teaching our residents, their ability to treat allergic patients can be as valuable as an annuity, for they can continue this type of practice when they can no longer operate, after they have had their coronaries (God forbid!), or when they decide to go into partial retirement.

The purpose of this presentation is to demonstrate how easy it is to incorporate allergic methods of diagnosis and treatment into the practice of otolaryngology.

Table 1

Frequent Manifestations of Allergy in Otolaryngology

Ears
- External Canals
  - Urticaria
  - Eczema
  - Pruritis
  - Contact dermatitis
- Eustachian Tubes
  - Edema
- Middle Ears
  - Edema
  - Secretory Otitis
  - Otitis media
  - Secretory mastoiditis
  - Persistent drainage
  - Conductive hearing loss
- Inner Ears
  - Vertigo
  - Tinnitus
  - Deafness

Nose
- Perrennial nasal allergy
- Hay Fever
- Polyposis
- Hyperplasia
- Recurrent or persistent "colds"
- Headache
- Edema
- Enlarged Adenoids

Paranasal Sinuses
- Membrane hyperplasia
- Edema
- Polyposis

Throat
- Stomatitis
- Glossitis
- Angioedema
- Recurrent sore throat
- Lymphoid hyperplasia
- Post-nasal discharge
- Hoarseness

Miscellaneous
- Periorbital edema
- Conjunctivitis
- "Allergic Salute"
- Adenoid facies
- Speech difficulties in children
- Cough
- Bronchia asthma
- Irritability
- Behavior problems
- Fatigue

†*Presented at the September 26 meeting of the Kentucky Eye, Ear, Nose and Throat Society during the 1963 Annual Meeting of the Kentucky State Medical Association at Lexington, Ky.*

**Former assistant professor of otolaryngology at Tulane University School of Medicine. Staff member and former president of the New Orleans Eye, Ear, Nose and Throat Hospital.*

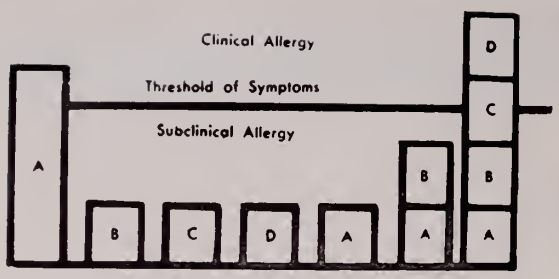


Chart 1. Demonstrotes effects of mossive exposure or summotion of exposure to severol ontigens.

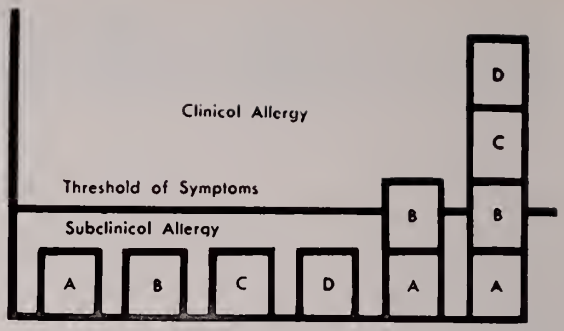


Chart 2. Demonstrates situotion existing when symptom threshold is low.

Obtaining Graduate Instruction

The first step which should be taken by anyone desiring to integrate definitive allergy diagnosis and therapy into an otolaryngological practice is to attend one or more of the excellent graduate instructional courses for physicians in the various divisions of medicine: these are periodically offered by the national allergy societies and by the Hansel Foundation and the American Society of Ophthalmologic and Otolaryngologic Allergy. In such courses the physician will learn something of the mechanism of allergy, its protean manifestations, the various types of diagnostic procedures available, specific and non-specific therapeutic measures, and the preparation of extracts for testing and treatment. It would be most helpful and prove a great saving of time if the physician could be accompanied to these courses by the aide who will be assisting him when he begins his office practice.

The Allergic Load

The physician can make a giant stride early in his career in allergy if he understands the concept of the allergic load[2]. It provides a simple and common sense approach to many of the problems of diagnosis and treatment that arise when dealing with allergic patients.

The "allergic load" may be defined as the sum total of the factors which play a part in the production or modification of allergic symptoms in the allergic person. The factors may be either contributory or exciting ones.

Contributory factors are incapable of producing an allergic attack themselves, but they effect the person in such a way as to precipitate or aggravate allergic reactions. They may, for example, act by adversely affecting capillary function. Among contributory factors may be mentioned such mechanical irritants as dusts, chemical fumes, and pungent odors, infection, emotion, change in the weather, barometric pressure, temperature changes, endocrine imbalance, physical and mental exhaustion, malnutrition, and changes in mineral and lipid metabolism.

The specific or exciting factors are, of course, the antigens or allergens. The allergic load may be increased as a result of either massive exposure to a single antigen or simultaneous exposure to a number of substances to which a person is sensitive.

Examples of massive exposure are numerous. Ragweed pollen may not produce symptoms in an individual until the count reaches one hundred. Those sensitive to house dust may not have symptoms until they suffer massive exposure as during house cleaning.

Unfortunately, most allergic individuals are sensitive to more than one substance. Chart 1 portrays the sensitivities of a hypothetical patient who is sensitive to three common allergens and, in addition, is affected by weather change. Massive exposure to any one of the antigens might, of course, produce symptoms; on the other hand, when exposure is minimal, a combination of three or more present simultaneously might be required for symptom production. This summation effect, pushing the patient over the threshold of symptoms, serves to explain, at least in part, some frequently encountered phenomena, e.g., why allergic patients can sometimes eat with seeming impunity a food that will precipitate a crisis at other times, why certain foods may cause symptoms only during a particular season, or when used in combination with other foods, why an upper respiratory infection may produce asthma in a certain individual at a time when the load is heavy but not at another when the load is light. The object of therapeutic measures is to reduce the load.

Chart 2 represents a patient whose symptom threshold is low due to lowered resistance in the form of insufficient protective antibodies, or, perhaps, to the presence of contributory factors such as were previously mentioned. Symptoms will be produced in such a case even though contact with the allergen, or allergens, seems relatively mild. Such lowering of the threshold of symptoms may be more apparent than real; an individual may have numerous sensitivities or, perhaps, a fairly high degree of sensitivity to a number of substances. Allergic management of such cases is difficult.

An individual may have a high threshold of symptoms (Chart 3) due to the fact that the degree of sensitivity is low or the number of sensitivities is few.

In the schematic representations it will be noted that reference is made to a state of subclinical allergy. This means that a person may be sensitive to one or more substances which do not produce symptoms except under certain conditions of massive exposure, concomitant exposure with other allergens, or when the symptom threshold is lowered. Actually, everyone may be thought of as having subclinical allergy.

The Diagnostic Investigation

Undue emphasis has been placed on the use of skin tests in the diagnosis of allergic diseases. While their importance should not be minimized, it must be remembered that skin tests are but one of the diagnostic tools available to establish the allergic nature of a disease and the etiologic factors producing it.

Were one to list in order or decreasing importance the methods to be used in establishing the diagnosis of otorhinologic allergy, our experience indicates that the results would be as follows:

1. The history
2. Cytologic examination
3. Skin and other diagnostic tests
4. Physical examination
5. Roentgenologic examination.

The Allergy History

The object of the allergic history is threefold; (1) to uncover the offending agent or agents, (2) to delineate the patients complete allergic symptomatology, including its development, and (3) to give an insight into all aspects of the patients medical problem.

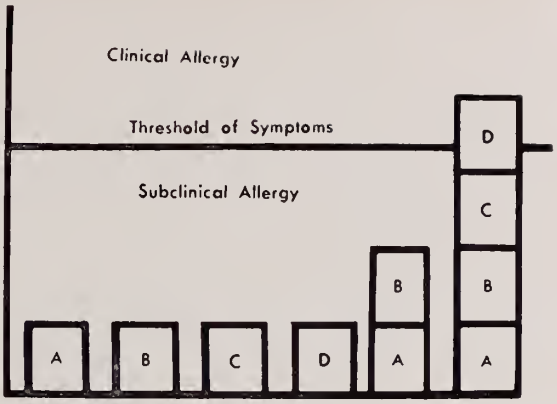


Chart 3. Demonstrates situation existing when symptom threshold is elevated.

To save time and to ensure completeness, we[3] developed and use an Allergy History Questionnaire. This is filled out by the patient at home and mailed to us. We review it and later discuss more fully with the patient any promising areas uncovered by the questionnaire. Of course, we also take a "continuing history" each time we see the patient.

Cytologic Examination

It is difficult to understand how anyone can practice otolaryngology without using this valuable diagnostic tool several times daily. After examining many thousand nasal smears, we still cannot tell with certainty from the gross examination just what the microscopic picture will be—it may indicate allergy, but the findings may reveal an infection or a metabolic disorder.

When Hansel's method[4] is used, an aide will require only two minutes to prepare smears for examination by the physician. Perhaps no other test in medicine will give so much information for such a small investment of time and effort.

Skin Tests

Skin tests constitute only part of the allergy survey and are usually of little value unless they support the details of the history. Reliance solely on skin tests in making a diagnosis of allergy has resulted in poor diagnosis and failure to respond to treatment. The result has been patient resistance when an allergy survey and treatment is proposed.

In otolaryngology the types of skin tests generally used are: (1) scratch tests, (2) intradermal tests, and (3) patch tests.

Four types of reactions may be obtained as

a result of testing: (1) true positives, (2) true negatives, (3) false positives, and (4) false negatives.

Skin tests for pollen sensitivity are generally considered to be about 95% diagnostically accurate, while those for other inhalants are about 75% accurate. Skin tests for foods are, on the other hand, only about 30% accurate.

The "image" of allergy in the public mind has suffered because some physicians have tested some patients with 300 to 400 allergens. Actually, it is well known that people having chronic allergic symptoms are usually sensitive to those things to which they are frequently or constantly exposed; it makes little sense to test for things seldom contacted or eaten by the patient. Table II is a list of the inhalant allergens for which we usually test. Of course, occupational contacts are most important and one should test with the possibilities which exist from this source. Unger[5] has prepared a list of the chief allergens in occupational respiratory allergy.

Table II

Inhalant allergens for which testing is frequently indicated

Tree pollen	Flaxseed	Rayon
Grass pollen	Jute	Silk
Weed pollen	Gum acacia	Wool
House dust	Gum tragacanth	Cat hair
Atmospheric mold	Karaya gum	Dog hair
Feather mixture	Orris root	Hog hair
Paper mixture	Pyrethrum	Goat hair
Tobacco smoke	Nylon	Horse dander
Cotton seed	Kapok	Rabbit hair

Any indicated occupational respiratory allergens.

In our hands skin testing for foods proved so disappointing that we abandoned them many years ago in favor of provocative feedings as advocated by Rinkel[6].

Skin tests are not without danger, but it is possible to avoid, to a large extent, untoward reactions during skin testing by a number of common sense precautions[7].

Physical Examination

There are no physical signs which are absolutely characteristic of allergy; however, some occur frequently enough in connection with allergic disease that they may prove helpful in verifying the diagnosis.

The gross appearance of the mucous membranes depends largely upon the state of activity of the allergic process and the amount of edema resulting from it. The more edema there is, the grayer the color of the nasal mucous membranes will become until a pale light gray color is reached. Should infection supervene, the amount of hyperemic tint developing in the allergic mucosa depends upon the color of the membrane prior to the onset of infection. Very little hyperemia will occur in a pale gray membrane, but a great deal might be found in those cases which closely resemble the normal. For these reasons, it is not always possible to determine whether an acute exacerbation of symptoms is caused by an allergic reaction or an acute infection.

Practically all polyps encountered clinically are of allergic origin; they are usually multiple, arise either in the middle or superior meatus or within the sinuses, and are accompanied by other evidences of allergy.

Most individuals who suffer from chronic upper respiratory allergy will be found to have an increased amount of lymphoid tissue in the nasopharynx, the lateral pharyngeal bands, and on the posterior pharyngeal wall.

A frequent finding in allergic children is the so-called "adenoid facies' the main features of which are mouth-breathing, a heightening of the hard palate with narrowing of the dental arch, and a lengthening and narrowing of the face.

The presence of discrete globular masses of mucopus in the return after sinus lavage usually indicates that the condition is at least partly of allergic origin.

The finding of a fluctuating type of conductive hearing loss in the absence of any of the causes of this type of hearing loss should make one suspect an allergic factor.

A frequently encountered sign in allergic patients is pallor of the skin. Such pallor is often associated with a large number of food sensitivities.

Roentgen Examination

Roentgenograms of the sinuses should be correlated with the history, the symptomatology, the cytology of the secretions, and the physical examination.

The following are some of the features often found in films of allergic patients:

1. There is usually mucosal swelling in all the sinuses so that the impression obtained is one of generalized haziness.
2. There may be polyps within the sinuses or within the nasal cavity.

3. There will be marked lessening of the mucosal edema in allergic sinusitis after the administration of intramuscular epinephrine provided irreversible mucosal changes have not occurred.
4. The edematous membrane appears ballooned out and does not follow the outlines of the bony wall as it does in infections of the lining membranes.
5. If serial films are taken, the presence of transitory edema is more suggestive of allergy than of infection.

Treatment

Whenever one speaks of allergic therapy, we almost invariably think of hyposensitization by injection of small quantities of the allergenic substance; we too frequently overlook the fact that the patient would become completely asymptomatic if the offending allergen could be removed from his environment. Hyposensitization should be resorted to only when it is either impractical or impossible to eliminate an offending substance completely.

Drug therapy is not a substitute for elimination and hyposensitization measures, but it may be a valuable adjunct, particularly for emergency treatment or to terminate allergic crises.

Finally, there are a number of non-specific measures which are effective, possibly because of the stimulation of the pituitary-adrenal axis.

Treatment by Elimination and Avoidance

All types of allergy may be benefitted by elimination and avoidance. If success is not total, the allergic load may be so reduced that hyposensitization may be made considerably easier.

Most textbooks and laboratories will provide the physician with pamphlets detailing avoidance and elimination measures for various allergens. The physician may distribute these to the patient as different items are incriminated during the investigation. In the case of foods, similar lists are available to inform patients of the genetically related foods (because of the possibility of a common sensitizing agent in several or every member of a botanical family) and of the common sources of various foods (important because many foods eaten today contain numerous ingredients).

Treatment by Hyposensitization

Hyposensitization is a procedure by which one attempts to lessen the patient's sensitivity, or increase his tolerance, by repeated hypodermic injection, sublingual administration, or ingestion of the substances to which he is sensitive. The term is often used interchangeably with desensitization, but this is incorrect inasmuch as it is unlikely that desensitization ever occurs as a result of repeated administration of allergens.

In general, two systems of hyposensitization are currently used; the traditional macrodosage, and the microdosage method popularized by Hansel. A third method, hyposensitization based on the results of skin titration, combines some of the features of both of the above.

The details of methods of hyposensitization are readily available[4]. The preparation of supplies can be readily entrusted to a properly trained technician. The physician himself, however, should always personally supervise treatment.

Everyone should be aware of the following facts concerning hyposensitization:
1. The best results from hyposensitization are not as good as the results achieved when the offending allergen is eliminated from the patient's environment.
2. Best results are obtained in those cases wherein the skin tests confirm the history; hyposensitizing on the basis of skin tests alone is unrealistic.
3. Even when the results of hyposensitization are good, the patient may not be able to withstand massive exposure to an allergen.
4. The best results are obtained with hyposensitization therapy when complicating food allergies are adequately treated.
5. Hyposensitization is a dynamic, not a static, process. This emphasizes the necessity for constantly being on the alert for changes in the patient's sensitivity and the introduction of new allergens into the environment.

Results of Allergy Management

Quite naturaly, practically every patient who considers beginning a course of allergy therapy wants to know what are the chance for a "cure". They must be frankly told that allergy is a condition like diabetes—it can be controlled, but it is unlikely that it will ever be "cured" in the true sense of the word. Our

experience indicates that about 80% of the patients can be sufficiently benefitted to cause them to want to continue therapy. In this connection, it should never be forgotten that successful management of the allergic patient depends, to a large extent, on his cooperation. Our experience has been that the best cooperation is obtained from those patients whom we have "educated" allergically speaking and whose "education" is continued as the investigational and treatment program progresses.

Discussion

Otolaryngology was born as a surgical specialty in times when medicine had little more to offer the patient than surgical means to eradicate infection. The need then was for physicians specially trained to meet the particular problems posed by infection in the head and neck. The advent of sulfonamides and antibiotics drastically reduced the need for surgical intervention, but patients continued to develop ear, nose, and throat complaints. It was then found that in a very large proportion of these allergy was the etiologic basis.

The need today is for otolaryngologists who are trained to manage these problems. There is no doubt that the well trained general allergist can adequately treat uncomplicated cases of nasal allergy, but specialized training does give the otolaryngologic allergist an insight that enables him to probe more deeply into the dual aspects of otolaryngology and allergy which should cause him to treat more adequately the highly complicated cases which resist usual diagnostic and therapeutic measures. Furthermore, it is well to be always a realist in such matters; in but few instances is it financially feasible for the patient to engage the services of both the allergist and the otolaryngologist in order to obtain the complete treatment he requires.

Finally, training is so readily available and integration into the practice of otolaryngology so easy that allergy should be a large and rewarding part of every physician's therapeutic armamentarium.

Summary

1. A survey of some of the pertinent facts about otolaryngologic allergy is presented.
2. A plea is made for every otolaryngologist to incorporate methods of allergic diagnosis and treatment in his practice.

Bibliography

1. BLACK, J. H.: *Allergy in General Medical Practice* J. Iowa St. Med. Soc., 40:389, 1950.
2. ANDERSON, J. R., and RUBIN, W.: *The Allergic Load.* A.M.A. Arch. Otolaryng. 58:540 (Nov.) 1953.
3. ANDERSON, J. R., and RUBIN, W.: *History Taking in Allergy: Use and Analysis of a Questionnaire.* Tr. Am. Acad. Opth. 60:433 (May-June) 1956.
4. HANSEL, F. K.: *Clinical Allergy.* St. Louis, C. V. Mosby, 1953.
5. UNGER, L.: *Bronchial Asthma.* Springfield, Ill. Charles C. Thomas, 1945.
6. RINKEL, H. J., RANDOLPH, T. G., and ZELLER, M.: *Food Allergy,* Springfield, Ill., Charles C. Thomas, 1951.
7. HANSEL, F. K., and ANDERSON, J. R.: *Allergy in Otolaryngology,* Rochester, Minn., 1959.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

The Allergic Emergency Aftermath of Modern Therapeutics†

Part 2*

Joseph H. Shaffer, M.D.**
Detroit, Mich.

Allergic reactions to newer diagnostic and therapeutic aids are recognized with an ever-increasing frequency. Caution is recommended when selecting chemicals, drugs and biologicals for the study and treatment of patients.

Predisposing Factors in Drug Reactions

PRESUMABLY everyone may form antigenic drug-protein complexes and practically everyone is constantly forming antibodies. The question why some people become allergic to drugs and others do not cannot be answered. These are factors, however, that seem of importance.

Heredity

Hypersensitiveness is known to have a *hereditary* tendency. The so-called allergic diseases such as hay fever, bronchial asthma, eczema, and urticaria often run in families. Individuals with a past history of allergy may be more susceptible to drug reactions than those with negative personal and family histories of allergy. It is of considerable interest that anyone may become allergic to a drug even though there is no past history or even remote family history of allergy.

Some diseases and "drug reactions", according to Berryman, reflect total or partial absence of specific enzymes which seems to be an inherited trait. A similar deficiency exists in the newborn who is for the first few weeks of life "biochemically immature". Drug reactions or unexpected toxicity may be exhibited immediately after birth because of an inability to alter certain drugs into "inactive" products. Later in life, when enzyme systems are fully developed, the same drug would cause no difficulty. He states that patients who develop hemolytic anemia after primaquine are reportedly deficient in the cellular enzyme, glucose—6—phosphate dehydrogenase, which "protects" non-susceptible individuals.

Route of Administration

Allergic reactions to drugs are most common following *topical application* to skin or mucus membranes. Application of a medicated preparation to inflamed tissue, or in conjunction with substances that may produce inflammation, increases the hazard of inducing a sensitizing reaction. Under these circumstances there is opportunity for drug-protein complexes to be formed which may be readily absorbed into the bloodstream.

Parenteral administration of drugs. Whenever injections (intravenous, hypodermic, or intramuscular) of medications are given, there is increased risk of being confronted with the dreaded anaphylactic reactions. Parenteral administration of drugs combined with ingredients that delay absorption, or induce inflammation in the tissues, carries the increased risk of an allergic response of a prolonged nature. Freund and McDermott noted the accentuation of antibody formation when antigens were given together with a homogenate of a lanolin-like substance, and killed tubercle bacilli in paraffin oil (Freund's adjuvant). This principle is utilized when one employs the emulsion extract injection technique for the administration of inhalant allergens which are combined with Arlacel A and Drakeol in the treatment of individuals with pollenosis.

†*Presented at the annual meeting of the Kentucky Academy of General Practice at Louisville, May 8, 1963.*
**Due to the length of this article, it appears in two parts, the first of which appeared in the June issue of The Journal of KSMA.*
**Chief, division of Allergy, department of Medicine at Henry Ford Hospital, Detroit, Michigan.

Allergic reactions to drugs taken *orally* are, comparatively speaking, less common than when topical and parenteral administration is employed. Violent and fatal reactions may, however, follow the administration of a single tablet of acetylsalicylic acid, penicillin, or sulfa drugs.

Sensitizing Quality of the Drug

The chemical structure of the drug administered may to some extent predispose to allergic reactions. According to Berryman, drugs containing carboxyl, amino, or hydroxyl groups are more likely to combine with polypeptides, or amino acids in the body and thus become antigenic. Almost all effective drugs, however, contain one or another of the active chemical groups which may cause a similar response.

Associated Conditions

In certain diseases, there is apparently some interference with immunity mechanisms, and allergic reactions are unlikely, even in otherwise predisposed persons. Such is the case in Hodgkin's disease, and with certain antigens when used on a patient with sarcoidosis.

Patients with systemic lupus erythematosis are susceptible to sun sensitivity, drug and foreign protein reactions of various types; they frequently have hemolytic anemia or thrombocytopenic purpura in which abnormal antibodies are demonstrable. The incidence of drug allergy in patients with lupus erythematosis is so high that tests for lupus are indicated whenever an unexpected drug reaction occurs in a patient who has an illness of an obscure nature.

Prevention

Opaque substances, with iodide bases, commonly used in studies of the gallbladder, kidneys, and arteries have caused violent and fatal reactions.[18] Their use is strictly contraindicated in the iodide sensitive individual. Sulfobromophthalein used in liver function studies has caused violent and fatal reactions.[19] Congo red has practically been discarded as a liver function test for a similar reason. Local anesthetics of the 'caine group often cause such responses. Criep et al,[20] reported three fatalities due to allergic reactions to procaine hydrochloride. Reactions from cocaine, Xylocaine® and pontocaine occur all too frequently and may force a surgeon to perform a relatively simple operation with the patient under general anesthesia rather than risk a possible fatal reaction to one of these local anesthetics.

With the prevalence of a high degree of sensitivity to sulfonamides, containing acetylsalicylic acid, iodides, and antibiotics, it is imperative that we be on guard when prescribing remedies for the common cold. Spink[12] points out that antibiotics and the sulfa drugs have controlled many bacterial infections such as streptococcal diseases, pneumonia, and venereal diseases, but leaves the virus untouched. He states, however, that "one of the tragedies in all of our advancing medicine is for people to dip into a supply of antibiotics or sulfa drugs and take them in quantities without the advice of a physician for the treatment of a common cold—not because they're going to cure that cold, but because they will prevent something more serious."

Early evidence of drug allergy may be manifested by erythema, rashes, febrile reactions, and abnormal findings during studies of the blood. Early detection and prompt withdrawal of the offending drug is indicated. Omission of the medication, or substitution of another, is in order.

The acetylsalicylic-acid sensitive individual may be given sodium salicylate with impunity. Expectorants containing guaiac may be substituted for those containing iodides. Non-barbiturate sedatives may be used when there is intolerance to barbiturates. Tranquilizers should be selected and used with caution.[21] There is a risk in giving influenza vaccine to the egg-sensitive individual. A person sensitized to penicillin may react violently to traces of penicillin present in poliomyelitis vaccine.[22] Other potential allergens in this vaccine are monkey-kidney protein, streptomycin, phenolsulfonphthalein, thimerosal, formaldehyde, calf or horse serum, and various other antibiotics and substances used in the production of the vaccine.[23]

The penicillin molecule is the antigenic factor that causes reactions. Cross-allergenic reactions occur since the penicillin molecule, or "nucleus" 6 amino-penicillanic acid (6APA) is present in all of the various preparations of penicillin available to us today. Substitution of one formula for another, therefore, is not the answer.

Recent studies[24] on Cephalosporins, Cephalosporin N (Synnematin B) and a new form, Cephalosporin C (Cephalothin) in which the 5-membered thiazolidine ring of *6APA* is replaced by a 6-membered dihydrothiazine ring was not cross-allergenic with the penicillin

scries in skin tests. This would seem to indicate that Cephalosporin C may be administered to penicillin-sensitive individuals without causing constitutional reactions and still furnish the broad spectrum antibiotic effect for the treatment of those conditions which formerly required penicillin therapy. Some advocate skin testing with penicillin to screen out the reactor who may respond with anaphylaxis. Although tests may be negative, the patient may still have a fatal anaphylactic reaction. The skin test should be made with crystalline penicillin in dry form, reconstituted into aqueous solution at the time the test is done. Such a solution should be used within a week of preparation. A scratch test of a solution containing 1000 units per ml. may be applied. If negative, an intradermal test with 0.01 ml. may be applied. Tests should be examined within 15 minutes.

Hemagglutination studies have been used to determine the presence or absence of penicillin allergy. The Coomb's test is helpful. Parker et al[25] are currently working with a synthetic polymer, penicilloyl-polylysine, prepared with lysine and a breakdown product (penicillenic acid) of penicillin. Tests for penicillin sensitivity with this polymer have proven effective in their work. Shelley's[26, 27] work with the basophil shows promise as a test for not only sensitivity to antibiotics and chemotherapeutic agents, but for other antigenic test substances as well. Protein testing in allergic individuals as we know it today may well be supplanted by testing techniques such as Shelley has devised.

Tests for sensitivity to organ extracts are useful. Patch tests may be helpful in detecting the skin-sensitizing properties of certain drugs. Skin tests with chemotherapeutic agents on the basis of experience, in general, (with the exception of patch tests referred to above) are unreliable, unsatisfactory, and misleading in attempting to screen patients for sensitivities.

It is helpful and may prove life-saving to warn others of an allergic reaction in our patients. Reactions should be indexed in medical records, warning notes, or "flags" should be placed in office treatment files, cards for carrying in billfolds, lockets, bracelets, and "dog-tags" often prove helpful. Patients often report reactions to drugs, but claim that their doctor didn't tell them which drug was involved. This information should not be withheld from the patient.

Symptoms of Anaphylaxis

Symptoms that should warn us of impending anaphylaxis may occur before the injection needle is withdrawn or seconds, and not more than a few minutes, thereafter. Serious constitutional symptoms usually occur within 20 to 30 minutes after treatment—patients should always be asked to remain in the office or treatment area during this interval. Should the patient experience symptoms as listed below they are instructed to report back to the nurse or doctor at once. The patient may feel queer, uncasy, dizzy, or unusually apprehensive, or complain of feeling hot all over, with tingling of the lips, or itching of the palms, or may suddenly collapse. There may be generalized erythema which rapidly develops into urticaria. There may be a violent episode of sneezing, with a feeling of constriction in the chest with asthmatic breathing or gasping for air. The tongue may suddenly swell and blood-tinged mucus flow from the mouth. Such symptoms require the most urgent and heroic efforts without delay on the part of the physician.

Treatment

The emergency treatment of anaphylaxis, whether drug induced, or otherwise is the same. It consists of prompt and repeated hypodermic injections of 0.5 ml. of 1:1000 dilution of aqueous epinephrine hydrochloride. A delay in favor of any other medication or manipulation is dangerous.[28] Death can occur while attempting to start an intravenous drip—it is quicker to dilute epinephrine (0.1 ml. in 10 ml. saline) and inject it by vein, after giving the initial hypodermic injection. Hesitation in performing this rapid procedure may be fatal. Repeated injections of epinephrine may be required to maintain the desired pressor effect in an effort to overcome depressed vasomotor tone and hypotension.

As supportive therapy, we must maintain an airway for oxygen administration, render artificial respiration, administer fluids and pressor substances such as levarterenol bitartrite (Levophed®) 0.2 per cent solution given in doses of 4 ml. in 1000 ml. of fluid as a continuous drip, or Metaraminol bitartrate (Aramine) 1 per cent solution containing 10 mg. per ml. intramuscularly in doses of 0.2 to 1 ml., or, by intravenous drip, 2 ml. in 500 ml. of N. saline solution. Bronchospasm may be relieved with intravenous theophylline (Aminophylline) 250

to 500 mg. diluted in 250 ml. of 5 per cent glucose in sterile water by intravenous drip over a period of 15 to 20 minutes. Cardiac stimulants may be required, and body heat should be maintained. Antihistamines and steroids may be introduced into the follow-up treatment program at this point.

According to Lowell,[29] all that is known concerning the time interval between the initiation of therapy with steroid drugs and the first evidence of a therapeutic effect indicates that nothing is to be gained by giving steroids intravenously or otherwise as an emergency measure in acute allergic shock (anaphylaxis). Steroids given at the time of the acute reaction may, however, have a valuable therapeutic effect on allergic manifestations such as accelerated serum disease which may follow some hours later.

Equipment for handling an allergic emergency should be quickly and easily accessible. All treatment areas in our clinic have tourniquets, epinephrine 1:1000 in rubber stoppered bottles, tongue depressors, syringes, and needles within arm's reach. Intravenous equipment and fluids are instantly available on a tray beside a treatment standard. Oxygen can be quickly wheeled to any treatment area. An emergency tray is equipped with special syringes and needles sufficient for intramuscular and intracardial injections, and for intravenous infusion. Practice or "dry runs" should be held so that all personnel charged with the care of patients will be thoroughly familiar with the use of this equipment.

Summary

1. Although newer diagnostic and therapeutic chemicals, drugs, and biologicals have revolutionized the practice of medicine over the past several decades, their widespread use has resulted in an ever-increasing number of allergic reactions which have complicated the practice of medicine.
2. Diagnostic and therapeutic pitfalls are discussed. Care in selection of and route of administration of all drugs is necessary if we are to avoid serious and fatal allergic reaction.
3. Metabolic, or, degradation products of drugs have the capacity to combine with tissue proteins. Such hapten-conjugates become antigenic and may form antibodies, which, when re-exposed to the antigen initiates the allergic reaction.
4. Patients with a personal or family history of allergy are highly susceptible to reactions to drugs. This group of patients should be exposed to as few medications as possible. We should not, as some have intimated, be guilty of over-medicating our patients.
5. General measures to be considered in the prevention and treatment of allergic emergencies which may occur in office practice are discussed.
6. No clear-cut advantage is represented by many new drugs as compared to standard remedies. If high risk is involved, their use may not be justified.

References

1. Sherline, D. M., and Blackwell, W. J., *Anaphylactic Reactions to Chymotrypsin,* JAMA 181:1079 (Sept. 22) 1962.
2. Ersley, A. J., and Wintrobe, M. M., *Detection and Prevention of Drug-Induced Blood Dyscrasias,* JAMA 181:114-119 (July 14) 1962.
3. Nicoloff, D. M., Sosin, H., Peter, E. T., Leonard, A. S., Wangensteen, O. H., *The Effect of Cortisone on Peptic Ulcer Formation,* JAMA 183:1019-1021 (March 23) 1963.
4. Perry, H. M. Jr., *Multiple Reactions to Antihypertensive Agents During Treatment of Malignant Hypertension,* Ann. Int. Med. 57, 441-450 (Sept.) 1962.
5. Taussig, H. B., *A Study of the German Outbreak of Phocomelia (The Thalidomide Syndrome),* JAMA 180:1106-1114 (June 30) 1962.
6. *Report to the Council, Registry on Blood Dyscrasias,* JAMA 179, 888-890 (March 17) 1962.
7. Auerbach, S., Mainwaring, R., and Schwarz, F., *Renal and Ureteral Damage Following Clinical use of Renacidin,* JAMA 183, 61-63 (Jan. 5) 1963.
8. Kellerman, R. W., Tarlov, A. R., Brewer, G. J., Carson, P. E., and Alving, A S., *Hemolytic Effect of Therapeutic Drugs,* JAMA, 388-392 (May 5) 1962.
9. McCarroll, J. R., and Kilbourne, E. D., *Immunization With Asianstrain Influenza Vaccine: Equivalent of the Subcutaneous and Intradermal Routes,* New Engl J Med 259:618-621 (Sept. 25) 1958.
10. Berryman, G. H., *Drug Reactions Agent and Host,* What's New No. 215, 48-49, 1959—Abbott Laboratories.
11. Glaser, J., *Personal Communication.*
12. Spink, W. W., *Controlling Infectious Diseases,* The Bulletin of the Am. Coll. Phys., 3:264-265 (Sept.-Oct.) 1962.
13. Feinberg, S. M., *Allergic Reactions to Antibiotic and Biological Preparations,* from "Medical Questions and Answers," "The Allergic Patient," 3:1-3, (Sept.) 1962.
14. Quinn, E. L., and Colville, J. M., *Subacute Bacterial Endocarditis—Clinical and Laboratory Observations in 27 Consecutive Cases Treated With Penicillin V by Mouth,* New Engl J Med 264:835-842 (April 27) 1961.
15. Sharon, D., and Salovi, J., *Anaphylactic Shock After Vitamin B1 Intramuscularly,* Abstract—J. Allergy 33:55, 1962.
16. Bresnick, E., Woodward, W. K., and Sageman, C. B., *Fatal Reactions to Intravenous Administration of Aminophylline,* JAMA 136:397-398, (Feb. 7) 1948.
17. Zucker, A., Bendo, D., *Anaphylactic Reaction to Acth,* New York J Med, 61:623, 1961.
18. Hildreth, E. A., Pendergrass, H. P., Tendreau, R. L., Ritchie, D. J., *Reactions Associated With Intravenous Urography,* Radiology, 74:246, 1960.
19. Mallin, S. R. and Gambescia, J. M.: *A Fatal Reaction to Sulfobromo-Phythalein,* JAMA 174:166-168 (Dec. 3) 1960.
20. Criep, L. H., and DeCastilho Ribeiro, C.: *Allergy to Procaine Hydrochloride With Three Fatalities,* JAMA 151:1185-1187 (April 4) 1953.
21. Hollister, L. E., *Allergic Reactions to Tranquilizing Drugs,* Ann. Int. Med., 49:17-28, (July) 1958.
22. Pelner, L.: *Allergic Reactions to Poliomyelitis Vaccine Probably Due to Penicillin,* New Engl J Med 260:230, (Jan. 29) 1959.
23. Ruthig, D. W., *Sensitivity to Poliomyelitis Vaccine,* from "Questions and Answers" JAMA 183:229-230 (Jan. 19) 1963.
24. Stewart, G. T., *Cross-Allergenicity of Penicillin G and Related Substances,* The Lancet, 507-510 (March 10) 1962.
25. Parker, C. W., deWick, A. L., Kern, M., Eisen H. N.: *The Preparation and Some Properties of Penicillenic Acid Derivatives Relevent to Penicillin Hypersensitivity,* J Exp Med, 115, 803-819, (April 1) 1962.
26. Shelley, W. B., and Juhlin, L.: *New Serologic Test for Allergy in Man,* Nature, 195:1181-3 (Sept. 22) 1962.
27. Shelley, W. B., and Caro, W. A., *Detection of Anaphylactic Sensitivity by the Basophil Degranulation Response,* JAMA 182:172-178, (Oct. 13) 1962.
28. Bookman, R.: *Anaphylaxis,* in "Letters to the Journal," JAMA 180:87 (April 7) 1962.
29. Lowell, F. R.: *Clinical Uses of Steroids,* abstract, The Letters Of The International Correspondence Society of Allergists. Series XXV. 26-27, 1962.

Chondromalacia of the Patella†

Daniel G. Costigan, M.D.*, James M. Riley, Jr., M.D.**
and Fred E. Coy, Jr., M.D.***

Louisville, Ky.

Chondromalacia of the patella is a common knee joint disability. It is a precursor of osteoarthritis. Early the disease can be reversed. Later osteoarthritis supervenes. Diagnosis and treatment, both early and late, are described.

CHONDROMALACIA of the patella, as the name would indicate, is a degenerative disease affecting the articular cartilage of the patella. Generally speaking, most people have some degree of degeneration of the articular surface of the patella but fortunately, even though most people are affected, relatively few have symptoms which necessitate treatment.

The first description of this condition was by Budinger (1906-08) who described fissures in articular cartilage of the knee, usually the patella, which he considered traumatic in origin. There were other sporadic reports in the literature until 1928 at which time Aleman introduced the term "chondromalacia". He found degeneration of the patellar articular cartilage in one-third of the 220 knees that he operated and in 20 this was the only lesion.

Anatomy

The anatomy of the knee joint per se is not of significance in a discussion of this condition, but we are intimately concerned with what has been called the patellofemoral joint. This is the joint created by the relationship of the patella and the articular surface of the femoral condyles including the intercondylar groove. Little good would come of a description of the patella or femoral condyles except to say that in flexion and extension of the knee there is an intimate relationship between the two bones and their articular surfaces. Wiles et. al. have confirmed Wiberg's observation that the lateral facet of the patella is concave in two planes and makes contact with the femur through much of the range of motion. The medial facet of the patella is convex and touches the convex surface of the femur only at a single point except when the knee is flexed less than 60°.

The patella performs several functions, one of which has been emphasized by Steindler and must be considered in the functional anatomy of the patellofemoral groove. According to Steindler the arrangement of the patella anterior to the surface of the femur and the tibia deflects the line of pull of the quadriceps anterior to the center of the joint. This increases the strength of the muscle by improving leverage. The patella serves to protect the articular cartilage of the femur in addition to assisting in the normal lubricating mechanism of the joint. This latter function has been described by MacConaill and re-emphasized by DePalma et. al.

Further consideration of the functional anatomy must be centered on the quadriceps mechanism. As is well known the strength of this group of muscles must be maintained in good tone at all times and the line of pull through the muscle, patella, and insertion of the patellar tendon must be direct as possible, otherwise the patella obviously will be placed under abnormal stress at every motion of the knee joint.

Pathology

There are four distinct stages in degeneration of the articular surface of the patella in this disease. The first phase is described as a nodular swelling, usually found on the medial facet rather than lateral. The area of nodular swelling loses the blue-gray color of healthy

---

† *Presented at the September 24 meeting of the Kentucky Orthopaedic Society during the 1963 Annual Meeting of the Kentucky State Medical Association at Lexington, Ky.*

* *Assistant clinical professor of orthopaedic surgery at the University of Louisville School of Medicine.*

** *Assistant clinical professor of orthopaedic surgery at the University of Louisville School of Medicine.*

*** *Clinical instructor of orthopaedic surgery at the University of Louisville School of Medicine.*

articular cartilage and becomes grayish-yellow and lusterless. Microscopically at this stage metachromosis takes place. This is thought to be due to chemical change in the cartilage matrix. The chemical change is associated with lessening of chondroitin sulphuric acid in the cartilage matrix.

The next stage in the development is associated with fissures and flaking. It is at this stage that the cartilage has the appearance described elsewhere as a crabmeat appearance. Small fissures usually vertical or oblique, varying in depth, are found going from the anterior aspect of the articular surface of the patella and penetrating as far as the bony portion of the patella itself. The flaking that occurs at this time is quite similar and in essence means that a small area of the articular cartilage can be detached by lifting it upward but there is still enough elasticity left so that the flake slips back into place. This probably accounts for the "catch" complained of by the patients.

The next stage is that of erosion, at which time frank ulcer-like formation of the articular cartilage has occurred so that the bony portion of the patella may be protruding through the crater of the ulcer and the articular surface of the patella itself may be pock marked with one or more of these eroded areas.

The final stage is that of proliferation wherein stimulation of the underlying bone produces osteophytes. Typical osteoarthritic changes are evident.

Etiology

No single etiologic agent can be proved to be the cause of this disease. Trauma has been mentioned most prominently and this may be single or multiple. Such things as direct blows over the patella or multiple small traumatic incidences in which the patella is compressed against the articular surface of the femoral condyle as in kneeling, crawling, going up and down steps or squatting as is necessitated by many occupations, and abnormal pull of the quadriceps mechanism, alluded to earlier, as in knock knee or bowlegs, subluxation or dislocation of the patella, are examples of such trauma. Finally there are the not well understood biochemical changes that can occur in the synovial fluid or in the cartilage cells themselves. These changes, such as lessening of the chondroitin sulphuric acid content of the artilage matrix, are not well understood, and in fact it is difficult to say whether something else, such as trauma, precipitates this change or not.

Symptoms

The symptoms may be divided into those manifested early and late. Early the patient complains of generalized aching in the involved knee joint. Most of the time he is unable to localize the pain to any specific portion of the joint and generally indicates the anterior surface of the joint and occasionally the medial surface. Exercise, particularly going up and down steps or inclined planes, produces aching in the joint. Strangely enough there is stiffness of the joint after sitting which disappears after walking a few steps. The patient complains that the joint may be tight. This probably indicates mild effusion. A limp may or may not be present. If it is present it is usually transitory. When one joint is involved there is usually increased grating of the involved joint when compared with the normal joint. Later the pain becomes more chronic and severe. The patient complains that there is pain most of the time even on prolonged rest. *There is usually* effusion which is visible even to the patient at this time. The patient cannot climb steps squat down, or kneel without considerable disability. There is usually a limp associated with a very mild flexion contracture and the patient complains that the knee either locks or hangs on him and frequently gives away with him.

Physical Findings

The physical findings likewise can be divided into early and late. Early the findings are very minimal and can be readily confused with other conditions that create internal derangement of the knee. This is especially true of torn menisci. Crepitation, which is subpatellar in type, can be noted but early this is mild and is usually not significant. There is pain on compressing the patella against the femoral condyle and this pain is subpatellar in location. Pain can also be created by resisting the active upward thrust of the patella when the knee is extended. There may or may not be slight fullness of the infrapatellar fat pad. There is usually tenderness on palpation of the articular cartilage of the patella.

Physical findings in the later stages are a magnification of those noted in the earlier stages. The crepitation in the joint is more marked. There is usually a chronic effusion

present with fullness of the popliteal space and infrapatellar fat pad. There is usually catching of the joint on flexion. There may be a mild flexion contracture and there is usually slight atrophy of the thigh musculature.

X-Ray Findings

If x-rays are made early in this disease there are no particular abnormal x-ray findings. Later condensation of the bone underlying the articular cartilage of the patella can be noted in some cases and still later the typical findings of osteoarthritis with loose bodies, osteophytes and cysts are obvious.

Differential Diagnosis

Differential diagnosis must include consideration of meniscal tears, ligamentous sprain, osteochondritis dissecans, osteochondromatosis, villonodular synovitis, early gouty or rheumatoid arthritis and early tumor both of the synovium and of the bones themselves.

Treatment

Treatment is dependent on the stage in which the disease first presents itself. Early, avoidance of stair climbing, squatting, prolonged standing or walking, and reduction of weight is helpful. In addition, physical therapy measures consisting of warm packs to the knee with exercise of the quadriceps mechanism is done. The latter is done with the knee in full extension and no weights are lifted. As the symptoms abate, gradual extension of the patient's activities can be carried out within the limits of pain and good judgment. If the patient is seen when the disease is found to be advanced it is still well to try the conservative measures outlined above, including bed rest and cortisone injections into the joint. In the majority of cases this is sufficient to at least abate acute symptoms. If at the end of this time the knee returns to a relatively normal condition, as indicated before, extension of activity can be undertaken by the patient. If the conservative measures do not suffice or if there is a recurrence of symptoms on activity, surgery is usually necessary.

Surgical correction of this disease includes chondrectomy, either partial or complete, of the articular cartilage of the patella, patellectomy at which time the patella itself is removed and the quadriceps mechanism is repaired, or patellaplasty which includes either prosthetic replacement of the articular cartilage as advocated by McKeever and DePalma, or patellaplasty by the method of Cave-Rowe which entails use of the infrapatellar fat pad as a cover.

Summary

1. Chondromalacia of the patella is a common knee joint disease.

2. The pathology of chondromalacia is divided into four stages, with gradual progression of the disease and breakdown of the joint.

3. Symptoms and findings are related to the stage of disease.

4. Treatment is discussed, both the conservative and the operative.

References

DePalma, Anthony F., *Diseases of the Knee.*

DePalma, Anthony F., Sawyer, Blackwell and Hoffman, J. David: *Reconsideration of Lesions Affecting the Patellofemoral Joint.* Clinical Orthopaedics, No. 18.

Devas, M. B.: *Chondromalacia of the Patella.* Clinical Orthopaedics, No. 18.

MacConaill, M. A.: *The Movements of Bones and Joints. The Synovial Fluid and its Assistants.* British Journal of Bone and Joint Surgery, Vol. 32-B, May 1950.

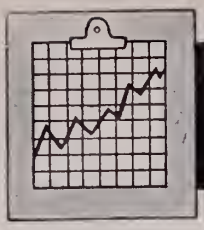
McKeever, Duncan C.: *Patellar Prosthesis.* American Journal of Bone & Joint Surgery, Vol. 37-A, October 1955.

Wiles, Philip, Andrews, P. S., and Devis, M. B.: *Chondromalacia of the Patella.* British Journal of Bone & Joint Surgery, Vol. 38-B, February 1956.

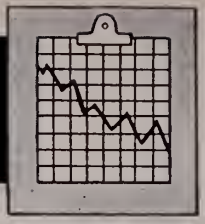
Wiles, Philip, Andrews, P. S. and Bremner, R. A.: *Chondromalacia of the Patella. A Study of the Later Results of Excision of the Articular Cartilage.* British Journal of Bone & Joint Surgery, Vol. 42-B, February 1960.

Remember Diabetes Detection Week

November 15-21



CASE DISCUSSIONS
From The
University of Louisville Hospitals



Evaluation of the Brain Injured Child

R. D. Brooke Williams, M.D., and Clifford I. Whipple, M.D.

THE Child Diagnostic and Evaluation Clinic has seen twenty-four children with brain damage since its inception in March, 1960. This includes some children with mental retardation due to brain injury and a few in whom it is difficult to assess the intellectual capacity. Others who appear to be retarded are found, after evaluation, to be suffering from a brain injury. A case report which follows is typical of such a case:

A ten-year-old boy, birthdate 5-19-1952, was referred to the Center on 4-2-1962 by a special education teacher because of the boy's great learning difficulty. The teacher had noted a lack of coordination with his hands, causing great difficulty in writing. He was generally slow, but apparently was a well-behaved student. The child's mother pointed out his lack of finger control, making it difficult for him to dress himself and to tie his shoes, button his shirt, etc. He usually walked with his right hand held upwords, never swinging it alongside.

Social Service Summary: He lived with his mother and maternal grandmother in a one-story old frame house in fair condition. The parents had separated before the birth of the patient ,who was an only child. The mother worked in order to support the boy.

Birth History: The mother had a long period of labor, lasting 36 hours. Labor was prolonged by slow dilatation, the head being extremely low. After 24 hours of poor progress, X-ray revealed an android pelvis, but adequate room for closed delivery. The membranes had been ruptured for three days at the time of the delivery. Uterine contents after passage of the baby were somewhat foul-smelling and meconium was present. The baby responded quickly to resuscitation, but did poorly from the beginning. (Shortly before delivery, the fetus showed signs of distress, according to the hospital record.) The infant was started on Penicillin at birth and was febrile for 24 hours. There was difficulty with respiration for three days after birth and it was thought that the baby had some evidence of intracranial damage, as he had some convulsive-like seizures for the first 24 to 48 hours of life.

Since birth, he had been admitted to the hospital on two previous occasions because of convulsive seizures, one episode with fever and the other without.

Pediatric Evaluation, 4-2-1962: The mother presented his difficulty as slowness in school work. She had been concerned about him ever since he was late in starting to walk. The main problems that concerned her were his lack of coordination and wondering whether he was capable of attending a normal school program.

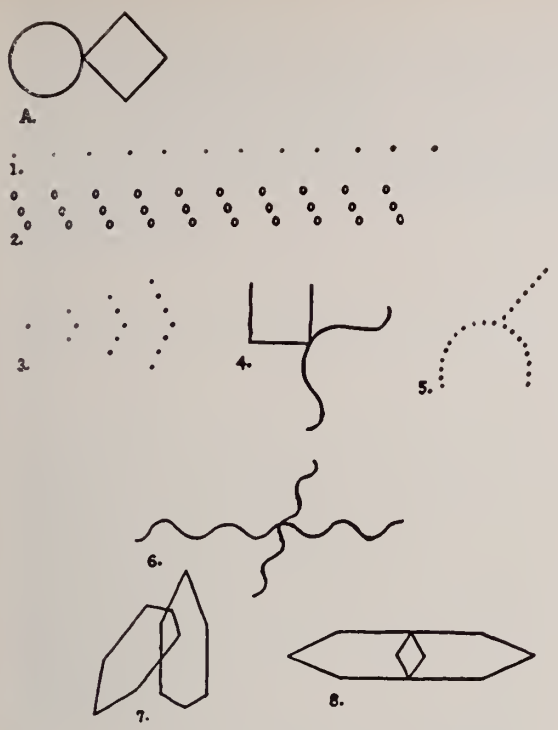
Problems of Infancy: The patient is reported to have had five or six convulsions which started on the right side of the body and involved the hand, arm, and leg. Most of these episodes had been associated with fever. The last convulsion occurred in 1960 and since that time he had been receiving Elixir Phenobarbital, one teaspoon three times a day.

Psychomotor Development (this is unreliable): The mother said that he walked at two. She is unsure of other dates. He was toilet trained at about two. He seemed to be slow in his speech and language. His self-help skills were complete, although he did no household chores. He could hold a pencil, scribble, and cut with scissors.

Social Adjustment, Emotional Development and Behavior: From information from the mother and our own clinical observations, we found that he followed directions, played in the yord, and enjoyed toys and games. He was obedient and responded to discipline. He was neither hyperactive, destructive, nor showed bizarre behavior. He played with other children, imitated, behaved in a group, and accepted strangers. He showed motivation to do things for himself. He would cry sometimes, if he did not get his own way. He showed affection to his mother, recognized danger, and played with a friend who lived next door.

Education: He completed a year in grammar school before the family moved. He then spent another year in regular class. He was then placed in a special class, where he seemed to get along well. He made good grades, especially in arithmetic, and satisfactory marks in the other subjects in the special class. According to the mother, he had a good memory for certain aspects of school work.

Physical Examination: He was a friendly boy, with a weakness and clumsiness of the right side of the body. Height and weight were below the 10 percentile of the Falkner[1] chart. There was a generalized ichthyoid condition of the skin. The child communicated with the examiner and was able to understand most of the simple requests given to him. He used sentences in conversation, speech being approximately normal for his age. There was a slight right facial weakness, including the muscles of the right eye. No actual weakness could be detected in the muscles of the extremities and there was no atrophy. Coordination was poor in the right upper extremity.



Test figures adapted from Wertheimer.

Figure 1 reproduced with permission of the American Orthopsychiatry Association.

Figure 1.

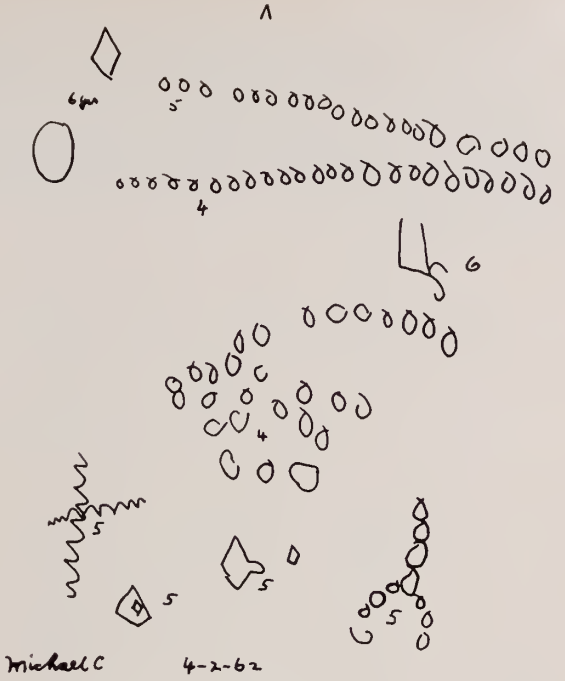


Figure 2.

He was left-handed. His mother stated that he sometimes seemed to be unable to recognize objects close to him, which suggested some visual agnosia, although this could not be detected. He seemed to have some difficulty in responding to questions immediately, although the audiological consultation revealed normal hearing in all respects.

Laboratory Data: PPD, .0001 mg: negative. Histoplasmin skin test: positive (8 to 10 mms. erythema). The electroencephalogram was moderately dysrhythmic with an irritative focus present in the right temporal region. Skull X-rays showed no abnormal intracranial calcification and the chest also appeared normal. Bone age was retarded, being approximately eight years. Chromatograms of the urine, including a phenylpyruvic acid test, were negative. Stools were negative for ova and parasites. The child and the mother were both Group B, Rh positive. The spinal fluid contained 1 white cell with total protein: 14 mgs. per cent; sugar: 63 mgs. per cent; blood sugar: 90 mgs. per cent. Routine urinalysis: negative. White blood count: 6,400. Hemoglobin: 12.6 gms. Hematocrit: 37 volumes per cent. Differential white blood count revealed 51 segs. 40 lymphs, and 9 monos.

Consultations: ENT consultation revealed hypertrophied tonsils and tonsillectomy and adenoidectomy were recommended.

Ophthalmological consultation caused the patient to volunteer that visual acuity of his left eye was not as good as that of the right. His mother had noted that he seemed to turn his head to the side occasionally when watching television. There was a 7 degree left exotropia and a slight left hypotropia. In depression, the child had a marked exotropia of 15 to 20 degrees, due to a weak inferior rectus, probably on the right. He had an overactivity of the superior oblique, noted best on looking down to the right. Impression: left exotropia, hypotropia, probably due to paresis of the right inferior rectus; possible refractive error; probably amblyopia; exanopsia, mild, secondary to his left exotropia.

Neurological consultation revealed a mild right hemiparesis and right facial weakness.

Psychological Testing: The patient received a thorough psychological evaluation which included testing by two psychologists. He was given the Stanford-Binet Intelligence Test, Form L-M, the Wechsler Intelligence Scale for Children (WISC), the Good-enough Draw-A-Man test, and the Bender-Gestalt Visual Motor Test.* The following scores were obtained from the standard intelligence tests: Stanford-Binet IQ-70; WISC: Verbal Scale IQ-79; Performance Scale IQ-89; Full Scale IQ-82; Draw-A-Man IQ-88.

The test results were indicative of a child in the borderline range of intelligence. From the test scores, one can observe an individual who does slightly better with performance tests than with verbal tests. The most salient characteristic of his test performance was the significant difficulty he had with tests involving concentration, concept formation, and visual motor coordination. The Bender-Gestalt drawings (see Figure 1 for normal design, Figure 2 for patient's reproduction) were quite poor. The Bender drawings are rather primitive for a child this age. It was

*Copyright, the American Orthopsychiatric Association, Inc. Reproduced by permission.

observed that he used loops instead of dots and there was form distortion on almost every design. The patient had trouble with arcs and angles, and perseveration in his drawings was quite prominent. The distortions found in the Bender-Gestalt drawings along with his performance on the Intelligence Test would lead one to suspect some neurological disturbance. His drawing of the human figure is very revealing. It was observed that he drew a man in detail. It was further noted (see Figure 3) that the patient drew a lop-sided individual, with his left arm and leg smaller than the right. Since the boy is left handed, one cannot help but feel this is a mirror self-image.



Figure 3.

Diagnosis: After all consultations had been completed, the patient was discussed in conference. The staff agreed that this child definitely had some brain injury which was interfering with his school work. Since he was unable to hold a pencil in his right hand, it was our opinion that he would benefit from some physiotherapy if this could be arranged locally. Further evaluation of his vision should be made. The final diagnostic impression was: Mild right hemiparesis, due to birth injury; right facial paralysis; left exotropia and hypotropia, probably amblyopia; congenital ichthyosis; latent seizure disorder; perceptually handicapped child.

Recommendations included a special educational program which would incorporate training which has proven to be of value with the brain injured child. It was felt that he might be a candidate for regular classroom placement after a proper training program. It was further recommended that he continue on his anti-convulsive medication.

Discussion: In certain cases of mild brain injury, the importance of differential diagnosis may be great, to rule out psychosis, neurosis, or mental deficiency[2]. Pasamanick[3] pointed out that frequently the histories of these children reveal complications of maternal pregnancy, prematurity, and paranatal difficulties. He suggested a continuum of reproductive casualty, extending from death through varying degrees of neuropsychiatric disability, including some children with minimal brain damage. In another article[4], this author gave evidence that cerebral palsy, epilepsy, mental deficiency, behavioral disorders, and reading disabilities were found to be significantly associated with complications of pregnancy and prematurity. Such included the toxemias and various types of bleeding.

In a study of 992 term and premature infants, Knobloch[5] reported that there was a significant increase in the incidence of serious neurological abnormality of 8.2% in the premature group over 1.6% in the controls.

In many cases, the onset of the brain damage can be traced to early childhood. Pond[6] reported the onset of the brain damage was, in more than half his cases, under two years of age, with birth factors being by far the largest single cause of brain damage.

The importance of identifying these children so that maximum efforts can be made to minimize the disturbances in perceptual and conceptual functions by special techniques of education owes much to the work of Strauss[7-8]. Failure to recognize the problem in children with no neurological findings is easy. Emotional and behavioral problems in these children are extremely common. However, in most cases, Paine[9] has shown they will abate to some extent with alteration of handling the child. Paine believed that parents and teachers found it easier to make certain required concessions when they came to understanding the discrepancy between the child's performance in some school subjects was inevitable and not a result of willful neglect or laziness.

Summary

The importance of identifying as soon as possible children who have significant disturbances in perceptual and conceptual functions cannot be overemphasized. Many of these children have difficulty in areas of learning which involve symbols. It is frequently difficult to recognize problems in children who have no neuological findings. However, these subtle, but none-the-less, complex problems can be detected by proper pediatric, neurological, psychological, and audiological consultants working as a team.

References

1. Falkner, F., *"Some Physical Growth Standards for White North American Children,"* Pediatrics, 29, pp. 467-474, 1962.
2. Clemmons, R. L., *"Minimal Brain Damage in Children,"* Children, Vol. 8, p. 179, 1961.
3. Pasamanick, B., *"The Epidemiology of Behavior Disorders of Childhood."* Research Publications of the Association for Research in Nervous and Mental Disorders, Proceedings, Vol. 34, p. 397, 1954.
4. Ross publication, *Feelings,* Vol. 5, no. 6., 1963.
5. Knobloch, H., *"Neuropsychiatric Sequelae of Prematurity,"* Journal of the American Medical Association, Vol. 161, p. 581, 1956.
6. Pond, D. A., *"Psychiatric Aspects of Epileptic and Brain Damaged Children,"* British Medical Journal, Vol. 2, p. 1455, 1961.
7. Strauss, A. A., and Werner, H., *"Disorders of Conceptual Thinking in the Brain Injured Child,"* Journal of Nervous and Mental Diseases, Vol. 96, p. 153, 1942.
8. Strauss, A. A. and Lehtinen, L. E., *Psychopathology and Education of the Brain Injured Child,* Grune and Stratton, New York, 1950.
9. Paine, R. S., *"Minimal Chronic Brain Syndromes in Children,"* Developmental Medicine and Child Neurology, Vol. 4, pp. 21-27, 1962.

SPECIAL ARTICLES

Answers to Your Questions on the Medical Care Program For the Dependents of Uniformed Services Act (P.L. 569)*

AS a means of bringing you up to date on information relating to the true Medicare program, the following questions and answers are carried below.

This material refers to the program for providing certain medical services to the dependents of active members of the Armed Forces. This is the original Medicare program and bears no relation whatever to the proposal now before Congress which would provide compulsory medical care for the aging under Social Security, often referred to as "medicare."

Q. *Who are eligible dependents?*

A. Lawful wife, lawful dependent husband, unmarried legitimate children (including a stepchild, legally adopted child, or legal ward who has not passed his 21st birthday.) Dependent children over 21 years of age are eligible for benefits if they are incapable of self-support because of mental or physical incapacity which existed before they reached 21 years of age or if they are enrolled in an approved institution of higher learning and have not passed their 23rd birthday.

Q. *Must a military dependent use a government hospital if one is available.*

A. Wives and dependent husbands and children of Service members, who reside *with* their sponsors and who desire medical care at Government expense, *must* contact a Uniformed Service authority to determine whether the required care can be provided in a nearly Uniformed Service medical facility. If it cannot be provided, the dependent must obtain a "Medicare Permit" or the new "Nonavailability Statement"—DD Form 1251—*from the appropriate Service authority* in order to have authorized care from civilian sources paid for by the Government. The issuance of DD Form 1251 places the dependent residing with the sponsor in essentially the same free-choice position as a dependent residing apart from the sponsor. In some cases, authorized Government-paid medical care from civilian sources may be provided *without a DD Form 1251*. These are:

1. Acute emergency requiring immediate treatment.
2. When the dependent is away from the area of the sponsor's household on a trip.

Q. *Does the Government contract for services with Blue Shield?*

A. No. The Government contracts with the Kentucky State Medical Association. Kentucky Physicians Mutual, Inc., is the fiscal agent.

Q. *Is participation by physicians voluntary?*

A. Yes. A physician may refuse to accept a Medicare patient without stating a reason therefor.

Q. *Does the Medicare payment represent full payment?*

A. When a physician accepts an eligible dependent as a Medicare patient, he agrees that payment will be made from public funds and that such payment will constitute payment-in-full for those services covered by the Program. One exception: when the patient is required to pay the first $15 of the attending physician's authorized charges (outpatient basis), the Government pays the balance.

Q. *What are maximum allowances?*

A. Physicians receive the aggregate of their customary charges for authorized care, or the aggregate of the appropriate maximum allowances which are shown in the Medicare Manual and Schedule of Allowances, (established by the Government and Kentucky State Medical Association), whichever sum is less. Exception may be made when a case involves special and extraordinary effort supported by a complete clinical summary attached to the claim form.

Q. *Is a dependent automatically covered when the person enters military service?*

A. Dependents of servicemen are eligible for Medicare benefits as of the servicemen's active duty date. DD Form 1173 must be obtained as soon as practical, but there are conditions or means for payment of claims for authorized care when DD Form 1173 is not available.

Q. *When does the dependent's eligibility for civilian medical care end?*

It is recommended that members remove these sheets and place them in their 'Medicare Schedule of Allowances' Manual for future reference.

A. Civilian medical care ends when the—
(1) Sponsor retires, dies, is discharged from active duty or is divorced from the dependent. In case of maternity care an exception to the rule has been in effect since July 28, 1959—a dependent wife whose husband dies on active duty while she is pregnant may receive maternity care at Government expense.

Q. *What type of identification card do dependents have?*

A. The dependents will carry a Uniform Services Identification and Privilege Card, DD Form 1173. This card can or can not indicate that they are eligible for treatment from civilian facilities. On the back of the card there is indicated "civilian" and if this block is completed then they are eligible for civilian care.

Q. *Generally speaking, what type care is provided on an in-patient basis under this program?*

A. Acute medical conditions including acute flare-ups of chronic diseases are eligible for care. Surgical conditions, which in the opinion of the physician are medically indicated to alleviate physical suffering or to improve function. Acute emotional disorders, when this is a bona fide emergency.

Q. *Does Medicare make an allowance to the assistant surgeon?*

A. Yes, but the surgeon should use residents and interns when adequate and obtainable.

Q. *What allowance is made to the assistant surgeon?*

A. The allowance is 10% of the surgical allowance, but not less than $20, and never more than 50% of surgical allowance, but not to exceed $50.

Q. *Are consultations covered under Medicare?*

A. Yes. The allowance is up to $15 when a complete physical and history is not required. $25 is allowed with a complete history and physical.

Q. *Procedure Code 0042 (Termination Visit), located on page 23 of the Medicare Manual and Schedule of Allowances, refers to payment of a referring physician who terminates his care prior to, or upon hospitalization of, the patient. Is this still an authorized benefit?*

A. No. This benefit was deleted from the contract, and all practicing physicians at this time were notified with a copy of ODMC letter 16-58, dated 10/1/58.

Q. *How is the payability of a Medicare claim determined?*

A. The payability of a physician's medicare claim is determined by:
(1) The diagnosis.
(2) Clinical information.
(3) Certification of the physician.

Q. *Is out-patient care provided?*

A. Out-patient care is restricted to:
(1) Maternity care.
(2) Treatment of bodily injuries.
(3) Pre- and post-operative tests and procedures (limited to $75.00 before hospitalization and $50.00 after.)
(4) X-Ray therapy begun or prescribed during a period of authorized hospitalization.

NOTE: The patient is responsible for the first $15.00 of a physician's charge for treatment of out-patient injuries or office or home deliveries.

Q. *Occasionally, by necessity, I have to administer the anesthetic to my own obstetrical patient. May I file a claim for both maternity and anesthesia services?*

A. Yes. Fifty percent of the obstetrical anesthesia fee is allowable to the attending physician or surgeon who administers the anesthetic to a patient upon whom he performs delivery. The same applies to a surgeon or his assistant performing and other authorized surgical service under similar circumstances.

Q. *Under the Medicare Program, can a physician file for the maternity service before he renders the six-week post-partum care?*

A. Yes. He can submit his claim as soon after delivery as he chooses; however, a charge cannot be made for this service unless actually rendered.

Q. *Some of my obstetrical patients require injectable medication during their pre-natal care. Is there an allowance provided for any medication?*

A. Yes. Necessary drugs which are administered parenterally by the physician rendering the care may be charged separately at cost to him by listing on the billing form. (No additional allowance is authorized for the administering of the injection—this is part of pre-natal care.)

Q. *I have under my care a Serviceman's wife who is receiving prenatal care. Her husband will be discharged from the Service before she delivers. Will Medicare make a payment on the delivery after the Serviceman is discharged?*

A. Coverage ceases when the Serviceman is discharged. The delivery case or any charges after discharge of the Serviceman would not be covered under Medicare.

Q. *Is it permissible to report a claim to Medicare for routine newborn care and circumcision on the same claim that is submitted for maternity care?*

A. Yes. Routine nursery care and circumcision of a newborn may be billed on the same claim form submitted for maternity.

Q. *Are neonatal visits authorized on an out-patient basis?*

A. No. Neonatal visits were formerly authorized on an out-patient basis but this service was deleted from the program in 1958.
NOTE: The Medicare Manual and Schedule of Allowances shows, "Neonatal Care as an authorized item under codes 0048 and 0049." These codes should be deleted since the care is no longer authorized.



Gastric Ulcer

CRITICISM has been directed to the use of the term "peptic ulcer." It continues to be employed generally, however, to designate acute and chronic lesions of the mucosa of the intestinal tract whether they occur in the esophagus, stomach, duodenum, or, more rarely, in the jejunum or ileum. It is very probable that the wide spread of location of such a lesion represents fundamentally the same disease and arises from the same general etiological factor with, of course, some variation. For instance, esophageal ulcer is more likely to occur in chronically ill or bed-ridden patients or with those in whom there is some defect in the patency of the cardioesophageal mechanism which allows reflux of acid gastric juice into the esophagus. Just why peptic ulcer occurs with such high frequency in the first portion of the duodenum and is relatively rare in the jejunum or ileum is not very satisfactorily explained.

In proportion to duodenal ulcer it appears that gastric ulcer occurs with relative infrequency; this difference may be more apparent than real however since in autopsy surveys the evidence of gastric ulcer approaches the frequency with which the disease is discovered in the duodenum. The difference observed in clinical experience may be due in part to greater difficulty by x-ray examination in localizing the lesion in the stomach than in the duodenum.

Some differences in the symptomatology and physical signs in the patient with gastric ulcer as compared with those of duodenal ulcer may be observed. Pain is the most constant symptom of duodenal ulcer and has some periodicity or rhythmic occurrence with relation to ingestion of food. Pain appears to be less characteristic of gastric ulcer and is often of a somewhat different character. For instance, an ulcer occurring in the pyloric channel is more likely to be associated with a colicky pain or nauseating type of discomfort than when it occurs elsewhere. One located in the pars media or fundus of the stomach is often associated with very vague or indefinite pain or actually none at all.

The patient's localization of pain in the left epigastrium is often very suggestive of gastric ulcer whereas the pain of duodenal ulcer is more likely to be in the right epigastrium or gallbladder area. Likewise, in the palpation of the abdomen tenderness is more likely to be elicited in the separate areas in connection with the two different locations of the ulcer.

The medical treatment of peptic ulcer whereever it is localized in the intestinal tract is fundamentally the same. The disease is usually associated with some increase in gastric secretion; an ulcer can very rarely, if ever, be found in the presence of histamine-fast achlorhydria. Therefore, frequent and regular feedings of food and frequent use of antacid preparations constitute the accepted basis for treatment for peptic ulcer wherever it may occur.

The single characteristic of greatest importance in gastric ulcer is the constant problem as to whether the lesion is benign or malignant and because of this the occurrence of gastric ulcer always presents a very special and difficult problem. The size, location within the stomach, duration of the disease nor the physical characteristics of the lesion as demonstrated by x-ray cannot be relied upon singly or in any combination to prove whether the lesion is malignant or benign.

The x-ray appearance of a gastric ulcer provides, of course, the most commonly used criterion in determining whether surgical interference is indicated. The location, size, depth of the crater, and whether it protrudes beyond the border of the stomach, and the pliability of the gastric wall in the region of the lesion are the usual characteristics upon which a decision regarding malignancy is determined. More than that, the general impression gained by the experienced roentgenologist of the overall appearance of the lesion is perhaps most to be relied upon.

Gastric analysis is important. It is generally accepted that a peptic ulcer does not occur in the presence of a histamine fast achlorhydria; however, the amount of hydrochloric acid and the volume of gastric secretion is usually more nearly at the normal range in gastric ulcer than it is in duodenal ulcer, and the presence of hyperacidity or hypersecretion can in no sense be relied upon to exclude malignancy. The presence of blood in the gastric juice likewise may be deceptive. Similarly, anemia and the constant presence of blood in the feces is more indicative of a malignant gastric lesion; but is not an entirely reliable guide.

Gastroscopic observation of the stomach is often a deciding factor when the size and appearance of the ulcer crater are viewed directly. The granular chronic bleeding appearance of the floor of the crater, the overhanging and often smooth chronic appearance of the margin, the nodular or pebbled nature of the surrounding mucosa are findings strongly indicative of malignant lesion and these characteristics are not appreciable by any other means than by gastroscopic or fiberscopic observation.

Biopsy taken at gastroscopic examination is occasionally the key although one which cannot be entirely relied upon unless positive. In a lesion removed at surgery a single biopsy of the ulcer margin or base is sometimes deceptive and only by multiple segments from the margin of the lesion is the evidence of early malignancy found. It is apparent that this thorough type of examination cannot be accomplished by gastroscopic biopsy.

Suction biopsy of the gastric mucosa has been a helpful adjunct in the diagnosis of diffuse gastric mucosal disease, such as chronic atrophic gastritis, but has proven of little benefit in the differentiation of benign and malignant gastric ulcer because of the focal involvement as well as the difficulty in obtaining a specimen of carcinoma which lacks sufficient pliability to be aspirated through a small hole. It is, however, a technically simple procedure and is a direct and accurate method for the diagnosis of gastric lymphoma.

Exfoliative cytology continues to be under intensive study for its value in the diagnosis of gastric malignancy. Reports by reliable investigators show well above 90% accuracy in diagnosis. The technic is tolerated less well by the patient than simpler intubations such as gastric analysis. After flouroscopic localization of the tube tip, back and forth lavages of normal saline with a 100 ml. glass syringe are instilled as forcibly as possible. The returns are immediately separated in a refrigerated centrifuge, to retard cytolysis, at 3,000 to 5,000 R.P.M. and the sediment then fixed in ether-alcohol and strained after Papanicolaou. This preparation, interpreted by an intelligent pathologist with both specific cytologic training and specific interest in gastric cytology, may attain 90% and more accuracy in the cytologic diagnosis of *all* gastric malignancies. However, in the best and most enthusiastic hands, only 60% accuracy has been attained in the differentiation between benign and malignant gastric ulcers and the method has yet to justify itself as decisive, or even practical, in this situation.

Opinion differs as to when surgical treatment in gastric ulcer is indicated. Few surgeons now feel that immediate surgery should be done for every demonstrated gastric ulcer. Hospitalization under careful observation and treatment and the use of the diagnostic mechanisms here outlined are indicated in any case. If a definite conclusion is not reached by any of these methods a re-examination by x-ray should be accomplished at the end of about two weeks of intensive and intelligent treatment. If the ulcer has disappeared or decreased in size by 50% or more and the patient's symptoms are significantly relieved surgery may safely be delayed for further observation. It must be remembered however that under ideal circumstances even a malignant ulcer may show evidence of healing and the close observation of the patient should not be discontinued in so brief a period. The persistence of the crater beyond this time or evidence of its continued failure to make a satisfactory response to medical management is fair indication for surgery.

A. Evan Overstreet, M.D.
Sam A. Overstreet, M.D.

ORGANIZATION SECTION

Variety to Keynote 1964 KSMA Annual Meeting Sept. 29 - Oct. 1 At Louisville Convention Center

Diversity will be the by-word at the 1964 KSMA Annual Meeting which will feature 17 guest speakers, a Transatlantic CPC, 15 specialty group meetings, symposiums on diabetes and athletic injury prevention, and nearly 100 technical and scientific exhibits.

"This value and variety, coupled with the expanded facilities of the new, air conditioned Convention Center in Louisville, should make the three-day meeting (September 29-October 1) one of the best to date," said George P. Archer, M.D., Prestonsburg, KSMA president.

"A communications center in the middle of the technical exhibit hall is another innovation of the '64 meeting and should result in greater efficiency in relaying messages," according to Doctor Archer.

Information on four guest speakers was announced recently. They are: Noble O. Fowler, M.D., Cincinnati, Ohio; guest of the Kentucky Academy of General Practice; H. Relton McCarroll, M.D., St. Louis, Mo., guest of the Kentucky Orthopaedic Society; George R. Prout, M.D., Richmond, Va., guest of the Kentucky Urological Society; and Charles R. Stephen, M.D., Durham, N. C., guest of the Kentucky Society of Anesthesiologists.

Discussion Topics To Be Varied

Doctor Fowler, professor of medicine at the University of Cincinnati, will speak on "Cardiac Diagnosis from Examination of the Arteries and Veins" at the general session on Tuesday morning, September 29. His topic at the KAGP meeting will be "Recent Advances in the Diagnosis and Treatment of Pericarditis".

A graduate of the University of Tennessee College of Medicine in 1941, he is currently professor of medicine at the University of Cincinnati. He is director of Cardiac Research at Cincinnati General Hospital and director of Postgraduate Training in Cardiology at the University of Cincinnati. A diplomate of the American Board of Internal Medicine and in sub-specialty of cardiovascular disease, he is the author of numerous articles and associate medical editor of The Heart Bulletin sponsored by the American Heart Association.

Doctor McCarroll will deliver a paper on "The Diagnosis and Clinical Management of Congenital Dislocation of the Hip in Infancy" at the general session on Wednesday, September 30. He will also speak at the Kentucky Orthopaedic Society meeting on Wednesday afternoon.

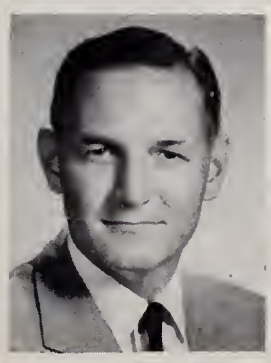
Associate clinical professor of orthopaedic surgery at Washington University School of Medicine, St. Louis, he is a past president of the American Academy of Orthopaedic Surgeons and the Orthopaedic Section of the American Medical Association. Doctor McCarroll is a graduate of Washington University School of Medicine in 1931 and is certified by the American Board of Orthopaedic Surgery. He is a member of the American Orthopaedic Association, American Academy of Orthopaedic Surgeons, and Clinical Orthopaedic Society.

Doctor Prout's talk before the general session on "Renal Homotransplantation in Modified Recipients" will be delivered on Tuesday morning, September

A digest of the actions of the AMA House of Delegates of its 1964 Annual Meeting in San Francisco June 21-25, together with a list of all Kentucky physicians attending this meeting, will appear in the August issue of the Journal. Because the AMA meeting was held at the deadline of this issue we were unable to have a full report.



Doctor Stephen



Doctor Prout



Doctor Fowler



Doctor McCarroll

29. He will address the urology group on Tuesday afternoon.

Professor and chairman of the Division of Urology, Medical College of Virginia, Richmond, Doctor Prout was certified by the American Board of Urology in 1959. He is a graduate of the Albany Medical College with an M.D. degree in 1947. Doctor Prout has had numerous articles published and has won several prizes and awards for essays and exhibits. He received first prize in 1962 for his exhibit on biochemistry and physiology of the prostrate at the AUA in Philadelphia. He is chairman of a research group involved with "Adjuvant Chemotherapy in Urological Tumors".

Doctor Stephen, a 1940 graduate of McGill University, Montreal, will address the Tuesday morning general session on "Hepatotoxicity in Anesthesia and Surgery". On Tuesday afternoon, he will address the anesthesiologists.

A native of Canada, Doctor Stephen became a naturalized American citizen in 1956. He is professor of anesthesia, Duke University School of Medicine; chief, division of anesthesia, Duke Hospital; and serves as a consultant in anesthesia at several hospitals. Editor of the *Survey of Anesthesiology,* he is is a member of the American Society of Anesthesiologists, a fellow of the American College of Anesthesiology, and a diplomate of the American Board of Anesthesiology. He has written two monographs and more than 100 scientific papers.

Perry County Starts "Pay-All" Blue Shield Plan

A "Pay-All" type Blue Shield Plan for residents of Perry County adopted by the Perry County Medical Society became effective on May 15.

At present an enrollment campaign is in process in the county, which has a low per capita income because of the decline of the coal industry in that area.

In the future, members of the county medical society will accept Blue Shield as full payment for covered services under the following conditions: (1) For individuals or families whose income is $3,600 or less per year, Schedule C Blue Shield allowances will be accepted as full payment; (2) For those with incomes above $3,600 per year, Schedule D Blue Shield will be accepted as full payment.

This action by the Perry County Medical Society took place after many months of consideration. All groups with five or more employees in the county are presently being canvassed by Blue Shield employees to give them the opportunity to participate.

Pathology Diplomates Announced

Five Kentucky physicians have been certified this spring as diplomates in pathology, the American Board of Pathology has announced. They are: Plutarco A. Santana, M.D., Harlan; Marthella J. Frantz, M.D., Edwin P. Jenevein, Jr., M.D., Leonard E. Wallace, M.D., and Daniel L. Weiss, M.D., all of Lexington.

Jefferson County Disaster Care To Get Plane Crash Test

Jefferson County's plans for rendering disaster medical care will get its first major test in handling over 150 "casualties" resulting from a simulated airplane accident at Bowman Field. The announcement was made by William T. Rumage, Jr., M.D., Louisville, chairman of the KSMA Committee on Disaster Medical Care and member of the AMA Committee on Disaster Medical Care.

Doctor Rumage said the exercise will be held in conjunction with a regional meeting of the AMA Committee on Disaster Medical Care which will be held at Stouffer's Inn, Louisville, July 25-26.

KSMA members are cordially invited to observe this practice test of community disaster plans which will include communications, traffic flow, triage teams, hospital plans, etc. It is suggested that those wishing to participate in this exercise meet at Stouffer's Inn, Louisville, July 25.

Hospital Statement Approved

Following the recommendation of the KSMA Advisory Committees to the University of Louisville and the University of Kentucky, the KSMA Board of Trustees approved for publication the following statement concerning the University Hospital.

"The primary function of the University Hospital is education. It is designed for the instruction of students and to facilitate the continuing postgraduate education of the practicing physician as well as the advancement of scientific knowledge through research. Regrettably, the University Hospital, therefore, must differ from a community hospital. Though offering care for as many patients as it is able, it cannot, in justice to its fundamental objective, accept all patients who present for admission."

Dr. Smith Honored by Students

A plaque citing Dean Donn L. Smith of the University of Louisville School of Medicine for his "contributions to the field of medicine, his devoted efforts toward progress at our university, and his sincere interest in student welfare . . ." was presented to the dean by the students at the honors day convocation at the school.



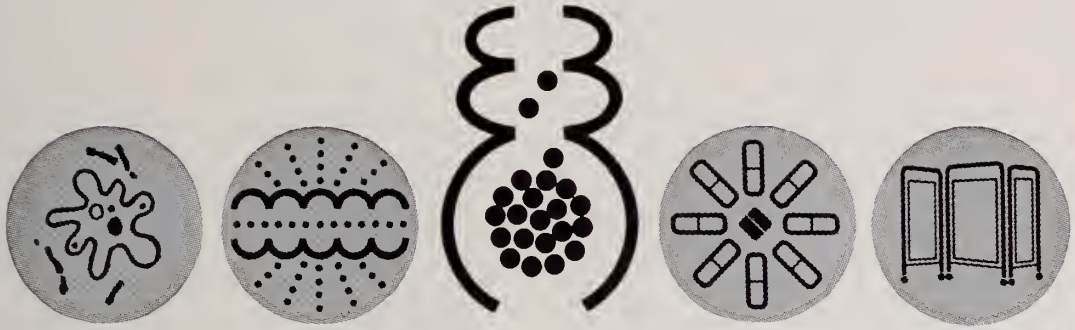
Doctor Smith

The honors-day is normally a student awards day, but this year the students turned the tables to honor Dean Smith with this surprise award. Ronald G. Goebel, Prestonsburg, was the winner of the dean's award for "constant pursuit of excellence"—an award which Dean Smith said would be given annually.

in virtually all diarrheas...prompt symptomatic control

LOMOTIL®

TABLETS / LIQUID—Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with inpaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Research in the Service of Medicine SEARLE

The Good Samaritan Proposal for Kentucky*

Approximately three years ago, on the instructions of the KSMA Board of Trustees, the Council on Legislative Activities prepared a bill for introduction at the 1962 General Assembly which undertook to relieve any physician who rendered emergency treatment at the scene of an accident, from any liability arising out of such treatment.

The theory behind the bill was at least plausible, its basic premise being that a physician who is merely passing by the scene of an accident and who may be unequipped to do his best, should not be subjected to the hazards of a damage suit if, out of the kindness of his heart, he stops and renders aid.

Upon further investigation, however, it was discovered that the Constitution of Kentucky contains this provision:

> *"The general assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property."*

It was found that the Court of Appeals had upheld the validity of this section and had struck down, as unconstitutional, a statute which had undertaken to absolve the owner of an automobile from liability to a non-paying guest for injuries sustained while riding in his automobile.

Accordingly, the bill was never introduced, but such a bill was introduced without the prior knowledge or consent of KSMA at the 1964 session. It failed to pass when it became known that KSMA opposed it. The Headquarters office continues to receive requests from individual members for sponsorship of a Good Samaritan bill, and this article is designed to explain to the membership why such legislation is not favored.

Needless to say, the unconstitutionality of such a bill is sufficient reason for not introducing it, but there are other, equally good reasons. It appears that the need for such legislation has been greatly exaggerated. Suits against physicians arising out of the situations described in the usual "Good Samaritan" bill are very rare. (J.A.M.A., May 26, 1962, p. 706)

Of even greater importance, however, is the unfavorable public image created by the efforts of the group best qualified to render first aid, to clothe itself with immunity, when everybody else is subject to suit. It is fundamental law that, although there is no obligation to assist a person in distress, one who nevertheless undertakes such a task must do so in a careful manner, and that assistance negligently rendered is actionable.

The point was eloquently made by Governor Otto Kerner of Illinois in his message of veto of a Good Samaritan bill recently passed by the Illinois legislature. Governor Kerner said:

> *"The essential unfairness of this type of statute can be appreciated when it is considered that any private citizen untrained in first aid, who volunteers in any emergency may be held legally accountable for his actions, as may a nurse who is less trained than the physician. But the doctor, who is the only one fully trained to render emergency care, would be the very one rendered immune by this Bill from the consequences of his negligent acts. And unlike the private citizen who responds, the action of the physician is not wholly voluntary, since fidelity to the precepts of his profession requires him in an emergency to render service to the best of his ability."* Principles of Medical Ethics of the American Medical Association, Sec. 5.

In view of all of the foregoing, physicians should forget about Good Samaritan legislation and continue to treat the injured wherever encountered, with all of the skill at their command, giving no thought to "passing by on the other side." Luke 10, 30-37.

KSMA Council on Legislative Activities
E. Gaines Davis, Jr., General Counsel

In an effort to clarify some of the misunderstandings concerning the proposed Good Samaritan Law in Kentucky, the KSMA Council on Legislative Activities presents this article.

Red Cross Commends Publications

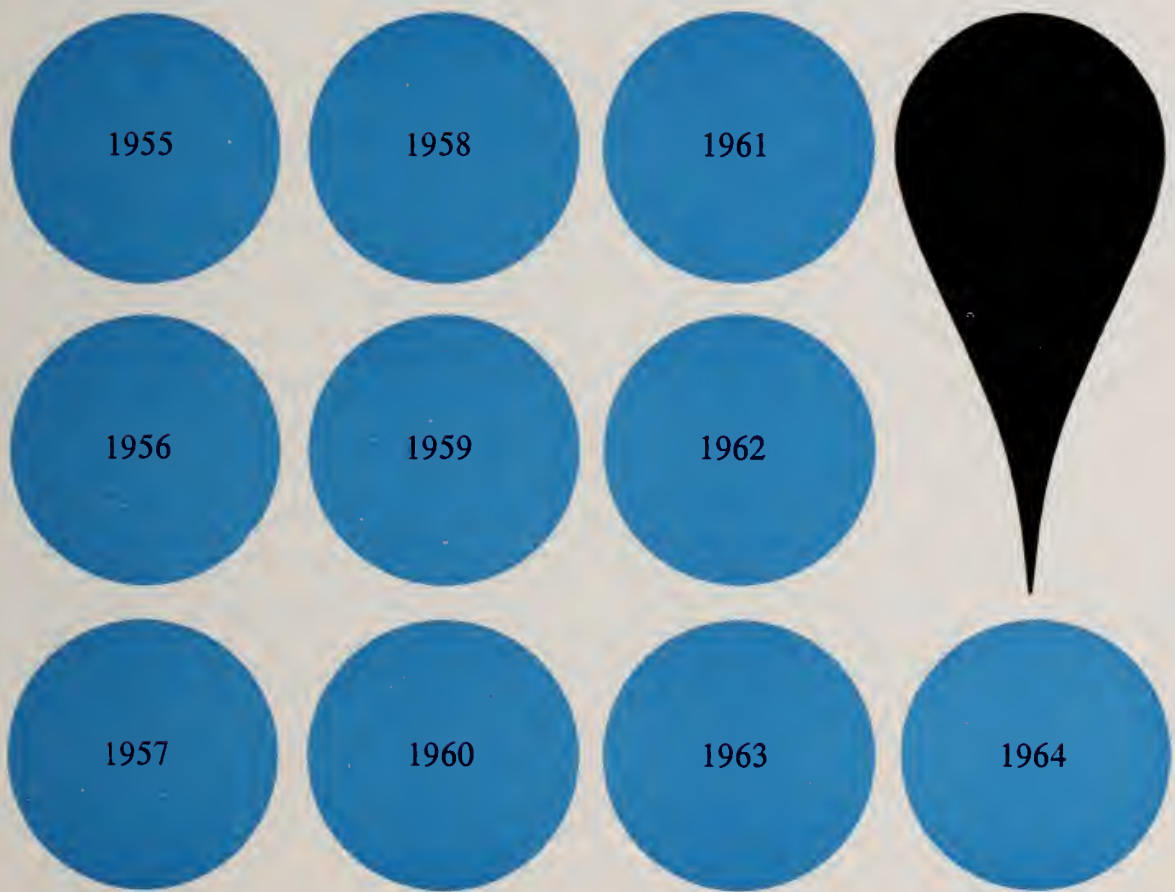
The Journal of the Kentucky State Medical Association and the *Blue Shield Newsletter* both received recent commendations from the Louisville Regional Blood Program, now celebrating its 15th anniversary.

Commendation was for "consistent service in communications to keep open the lifeline of 1,100 pints of blood a week . . . . and for immediate response to emergency blood needs . . ."

Hospital Unit Honors Dr. Bruce

James W. Bruce, M.D., a Louisville pediatrician for 44 years, received the distinguished-alumnus award of the Alumni Association of University of Louisville Hospitals at the annual dinner meeting at the Albert Pick Motel in Louisville early last month. Doctor Bruce has served on the volunteer staff of General Hospital for many years and has been associated with the medical staff at Kosair Crippled Children's Hospital.

The clear conclusion from 10 years' experience...



belongs in every practice

Miltown®
(meprobamate)

WALLACE LABORATORIES/Cranbury, N. J.

CM-2026

U. of L. Names Dr. Keller To Head Psychiatry Dept.

The appointment of William K. Keller, M.D., widely known Louisville psychiatrist, as head of the department of psychiatry at the University of Louisville School of Medicine, was approved at the June 17 meeting of the U. of L. Board of Trustees.



Doctor Keller

Doctor Keller has been acting head of the department since the retirement last July of S. Spafford Ackerly, M.D., who was reappointed psychiatrist-in-residence and distinguished professor of psychiatry at the same meeting.

Doctor Keller is a graduate of the U. of L. School of Medicine and has been on the faculty since 1938. He is a former president of the Kentucky Psychiatric Association and has spoken at many KSMA meetings across the state.

M.D.-Religious Groups to Meet

Various physician religious groups will have an opportunity to hold a breakfast meeting from 7 a.m. to 8:45 a.m. during the KSMA Annual Meeting on Wednesday, September 30. This innovation was passed by the Executive Committee of the Board of Trustees, approved by the Program Committee, and will be implemented by the KSMA Committee on Medicine and Politics.

Any religious group wishing to hold a breakfast at this time as an adjunct to the KSMA meeting, should contact William L. Woolfolk, M.D., Owensboro, chairman of the KSMA Committee on Medicine and Religion. The committee will assist the religious groups in making arrangements.

KSMA Woman's Auxiliary Praised For Health Careers Work

George P. Archer, M.D., president of KSMA, recently offered his high praise to the KSMA Woman's Auxiliary and its president, Mrs. J. M. Kinsman, Louisville, for "their outstanding efforts in furthering the interest in health careers among Kentucky's young people."

An inclusive report containing all available information on loan and scholarship aids available to those interested in careers in the field of health is only a small part of the work done by the Health Careers Committee and its cahirman, Mrs. Hoyt D. Gardner of Louisville. The purpose of the committee is to promote interest in medical, dental, nursing, and other health careers, such as medical and dental technology and occupational therapy.

The committee, in addition to supplying information on scholarship and loan funds available from other sources, also tries to provide one loan each year to a student in the health field. The money comes from surplus funds from operating expenses, plus contributions.

A health careers chairman is appointed in each county having an organized auxiliary, and members-at-large are requested to assist in the program in order to bring health careers information to as many young people as possible across the state. This is done by means of films, pamphlets, and other material distributed in local high schools, and by personal contact.

KSMA Field Service Director Resigns Effective July 1

Bobbie R. Grogan, who has served as director of Field Services of KSMA since June 1957, resigned his post effective July 1, 1964, to become assistant director of Vocational Education, State Department of Education, with offices in Frankfort.



Mr. Grogan

Mr. Grogan's chief duties with KSMA have been in the areas of Legislation, Rural Kentucky Medical Scholarship Fund, Placement Service and Rural Health program. He has also handled less important committee assignments.

The KSMA Board of Trustees cited Mr. Grogan along with a number of others, in a special resolution passed at the April 23 meeting, for the excellent services rendered the people of Kentucky and the medical profession during the 1964 session of the Kentucky General Assembly.

Mr. Grogan was with the division of Vocational Education prior to his employment with KSMA. Announcement of Mr. Grogan's successor will be made shortly, according to KSMA executive Secretary J. P. Sanford.

Dr. Denham Honored by Eastern

Mitchel B. Denham, M.D., Maysville, KSMA Ninth District Trustee, received Eastern Kentucky State College's 1964 Outstanding Alumnus Award during the Annual Alumni Day reunion at Richmond May 23. Doctor Denham, who was 1964 Majority Leader for the Kentucky House of Representatives, graduated in 1934 from Eastern.

He is a former recipient of the KSMA Distinguished Service Award and recently received, for the second time, the 'Citizen-Doctor of the Year' Award from the Kentucky Academy of General Practice. Doctor Denham received his M.D. degree from the University of Louisville in 1940.

:OMMEMORATING ITS *90th Anniversary*

)F DEDICATED SERVICE IN THE FIELD OF PSYCHIATRY



r almost a century, THE EMERSON A. NORTH)SPITAL, Inc. has been the haven and hope for human ngs distraught with nervous and mental disorders l conflicts. Located away from the tensions of the :side world, situated on 40 acres of beautiful private ate grounds—this dedicated hospital offers complete ychiatric treatment and care:

:very advancement in the field of psychiatry, proved herapeutic methods and the most modern procedures :ervices of an active medical staff composed of 20)sychiatrists, augmented by specialist - consultants from the major medical center of Cincinnati

- ample classification facilities and qualified psychiatric nursing
- full recreational therapy facilities
- conveniences and surroundings to assure the greatest comfort and most desirable benefits
- experience and knowledge gained in 90 years of successful operation
- approved by the Joint Commission on Accreditation of Hospitals

PAUL W. WATKINS, M.D.
Medical Director

ISABELLE DAULTON, R.N.
Director of Nursing

ELLIOTT OTTE
President

GRACE SPINDLER, R.N.
Associate Director of Nursing

Brochure and rate schedule available on request

HE *Emerson A. North Hospital* INC.

(FOUNDED 1874)

5642 Hamilton Avenue, Cincinnati, Ohio 45224
Telephones: 541-0135, 541-0136

Oldest private psychiatric hospital west of Alleghenies and largest in state of Ohio



Digest of Minutes of the KSMA Board of Trustees Meeting

April 22, 1964

The Board of Trustees held its third regular meeting of the year at Jenny Wiley State Park Wednesday, April 22. All the members of the Board were present except one and there were six guests in attendance. Following the approval of the President's Report and Headquarters Office Report, the recommendations of the Advisory Committee to the Editor were presented.

These recommendations included reducing the number of scientific pages to nineteen, alternating certain departments, deletion of the Washington Page and other suggestions designed to reduce the cost of publishing the Journal.

A recommendation from the Council on Scientific Assembly to increase from $50 to $100 the honoria paid guest speakers was not accepted.

A resolution expressing appreciation to the President, the Chairman and Co-Chairman of the Council on Legislative Activities, Mitchel B. Denham, M.D., Mr. Bobbie Grogan and all KSMA Key Men at all levels for the excellent work done during the Legislature was unanimously passed.

Eugene Conner, M.D., professor and chairman of the Department of Anesthesiology at the University of Louisville was elected the official historian of KSMA to succeed the late Emmet F. Horine, M.D.

The Board unanimously went on record endorsing the candidacy of Robert C. Long, M.D., Louisville, to succeed himself as a member of the AMA Board of Trustees when the Annual Meeting of the AMA is held in San Francisco in June.

As a matter of properly recognizing the Woman's Auxiliary to KSMA, the Board of Trustees adopted a resolution authorizing the operation of the Auxiliary as an adjunct of the Association.

Consideration was given to Resolution B submitted by the Campbell-Kenton County Medical Society to the 1963 KSMA House of Delegates. The House accepted the reference committee report sending the resolution to the KSMA Board of Trustees for its final disposition. After full discussion, the Board voted to return the resolution to the Campbell-Kenton County Society with the statement that "The Board is in sympathy with the inherent intent of the resolution," but felt it would not be able to specifically implement it.

Following consideration of the grievances, which involved a number of the districts, the Board turned its attention to the reports of the Councils.

The Chairman had pointed out that the House of Delegates had authorized each of the six KSMA Councils to delineate the duties of the committees under each council and make recommendations to the Board of Trustees. The purpose of this recommendation being to have on the record what the duties of each committee is and to make it available to each committee at the time of its appointment each year.

The Board then voted that as these recommendations of the Councils were approved, they would become the policy of the Association covering the broad duties of the committees. General duties of each Council are set forth in the Bylaws.

The recommendations for the duties of the committees under the Council on Scientific Assembly were approved.

The Board next considered the recommendations of the Council on Communications and Public Service. It accepted the recommendation from the Council that KSMA be permitted to endorse commercial advertising under the auspices of the association or county medical society concerning public service programs in medicine such as emergency calls, house call problems, dealing in good taste with factual medical problems. The Mandatory Indoctrination Program, approved by the 1963 House of Delegates, had been referred to the Council on Communications and Public Service for recommendations as to implementation. These were read and approved by the Board.

The recommendations for the delineation of the duties of the committees under this Council were approved. During the discussion of the duties of the Public Health Committee, the Board passed a motion requesting the Committee on Public Health to investigate encroachments by the State Department of Health on the private practice of medicine and report back at the next meeting of the Board. Other recommendations from the Council included the suggestion that shades for the Board Room be purchased and that an organization of physicians interested in the medical aspects of sports be set up. The Board accepted both recommendations.

The recommendation that the name of the Emergency Medical Services Committee be changed to the Committee on Disaster Medical Care was approved.

The next recommendation considered by the Board was from the Council on Medical Education and Hospitals. Proposals from this Council for the delineation of duties of each committee were approved. It also heard a recommendation from the Council relating to the dues of full-time faculty members, which was made by the Advisory Committee to the University of Kentucky to the House of Delegates. The Board accepted a recommendation for circularizing the membership with a questionnaire on town and gown problems. Other recommendations from the Advisory Committee to the University of Kentucky included a suggestion that the Journal is an area of common interest and communication between faculty members and practicing physicians. A second recommendation concerned greater participation of the faculty in the medical community. And the third and final recommendation was the acceptance of the following suggestion:

> *The primary function of the University Hospital is education. It is designed for the instruction of students and to facilitate the continuing postgraduate education of the practicing physician as well as the advancement of scientific knowledge through research. Regrettably, the University Hospital,*

therefore, must differ from a community hospital. Though offering to care for as many patients as it is able, it cannot, in justice to its fundamental objective, accept all patients who present for admission.

The next Council to report was the Council on Medical Services. The report of the proposed delineation of duties of the committees of this council were accepted with the revision of the wording of the statement covering the Medical Discipline Committee.

The next Council to report was that of the Council on Legislative Activities, which has no committees under it. There were two recommendations from this council. The first related to disappointment expressed by the members of the Council over reference committee action of the AMA House of Delegates on the KSMA resolution submitted at the Portland meeting relating to a course on medical civics and economics in medical schools.

The specific recommendation was: "That the strength and wisdom of the state medical association be called upon to offer this as basic priority to the AMA and that it be utilized in every effective way to see that this is passed." After discussion, this recommendation was accepted. The second recommendation related to the matter of developing a basic science examination as a part of the Medical Practice Act. The Board voted to authorize the Chairman to appoint a special committee working with the deans of the two schools and others to make legislative recommendations which would implement the intent of this motion.

At this point the Chairman of the Budget Committee to present the budget proposed for the 1964-65 associational year, Dixie Snider, M.D., Springfield, was recognized. It was explained that the Budget Committee had spent a full day in making its study of the budgeted needs of the association and that all recommendations in the committee's proposal were routine with the exception of one and that the Executive Committee had considered this budget early in April and had approved it. The Board approved the regular budget.

The recommendation of the Budget Committee changing the policy of KSMA's support to the Woman's Auxiliary was considered. The recommendation provided that a lump sum of money be made available to the new administration of the Auxiliary each year and that the Auxiliary handle its own fiscal affairs. It was explained that this had been made in consultation with members of the Auxiliary. This recommendation passed.

The report of the Memorials Commission was presented and approved by the Board of Trustees. The Board granted permission to the Commission to be highly selective in the items that it approved for use in the Museum in the Headquarters Office because of lack of space and gave permission to continue to contact those members of the Board who have not purchased Board Room chairs to call this matter to their attention. It was explained that twenty-three chairs have already been purchased and that recognition would be given in each situation. The Board accepted this proposal.

The Board voted to participate in the Health-O-Drama sponsored by the Allied Council on Medical Services only if Blue Cross and Blue Shield were invited to take part.

The Board of Trustees granted permission for a member of the Board to install in the Board room at the headquarters office a clock and for a member of the staff to erect a flagpole in front of the new headquarters office building.

The Board authorized the Chairman to appoint a special committee to study the matter of drug repackaging in Kentucky and voted to ask the State Board of Health to make available to the association more information on new programs it was undertaking except in emergencies.

Tentative date for the next Board meeting was set for Thursday, August 6. The Board adjourned after being in session eight hours and forty-five minutes at 5:45 p.m.

Cancer Conference Sept. 17-19

The Fifth National Cancer Conference, sponsored by the American Cancer Society, Inc., and the National Cancer Institute, is scheduled for September 17-19 in Philadelphia. Headquarters will be the Bellevue-Stratford Hotel. For further information write: Coordinator, Fifth National Cancer Conference, American Cancer Society, Inc., 521 West 57th St., New York 19, N.Y.

The Modern Physician



must spend many hours keeping himself informed so that he may better serve his patients and his profession. Today, a doctor refers cases requiring special techniques to those trained in handling them.

Just so, select your jeweler who must have training, experience and an established reputation for honesty and dependability. KENDRICK is such a jeweler, being a REGISTERED JEWELER of the AMERICAN GEM SOCIETY. Call on us at any time for expert advice and assistance in selecting quality gems. This service costs no more.

Kendrick
Jewelers since 1832
MEMBER AMERICAN GEM SOCIETY
619 SO. FOURTH ST. 584-5232



an easier way?

'METHEDRINE'® brand
METHAMPHETAMINE HYDROCHLORIDE

is an easier way to help control food craving & keep the reducer happy

With "hunger pains" abolished, the patient can shrug off the chains of psychogenic craving that bind him to his habit of overeating and cooperate cheerfully with the prescribed diet.

In obesity, "...our drug of choice has been methedrine (methamphetamine hydrochloride)...because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West. J. Surg. **59**:238 (May) 1951.

Description: Each scored tablet contains 5 mg. 'Methedrine' brand Methamphetamine Hydrochloride.

Dosage: 2.5 mg. (½ tablet) 3 times daily. May be increased gradually according to response; more than 10 mg. daily rarely is needed. The last dose of the day should not be taken later than 6 hours before bedtime.

Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

Supplied: Tablets 5 mg., scored, in bottles of 100 and 1000.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and
a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193

Blue Shield, Blue Cross Set Records in '63

All-time high records in enrollment and benefits paid to subscribers were set in 1963 by the 77 Blue Shield Plans in the U.S., Canada and Jamaica and by Blue Cross Hospital Plans, Inc., according to recent reports.

Benefits paid by the Blue Shield Plans topped the billion dollar mark for the first time in 1963. A total of $1,066,734,309 was paid to physicians for their services to a record number of subscribers and dependents. Blue Shield 1963 membership increased 2,545,635, to an all-time high of 53,450,349.

Blue Cross coverage was provided for over 59 million persons in 1963, an approximate increase of one million over 1962. An increase of 240 million in hospitalization benefit payments was recorded over the previous year.

It was also reported that Blue Cross completed contracts with four states during the year to administer benefits provided under the Kerr-Mills Act. This brings to eight the total number of states in which Blue Cross is participating in this program.

Blue Shield Performance Test Started May 18

A special nation-wide "Test of Performance" study of Blue Shield plans got under way May 18.

The aim of this survey is to measure Blue Shield Plans performance in terms of the relationship between Plan payment for selected services and the amount the physicians bill their patients for the same services.

By analysis of data submitted during this survey, Plans will be able to: (1) evaluate present levels of performance; (2) aid a number of large accounts in accurate appraisal of their employees' medical care coverage contracts; (3) develop a measure of Plan performance so that comparisons with other Plans under similar circumstances can be made.

Pre-tests conducted earlier this year by the Massachusetts and Alabama Blue Shield Plans received an 85 per cent response from area physicians. In this nation-wide survey, it is expected that questionnaires on nearly 475,000 Blue Shield claims will be submitted for evaluation.

Medical School News

U. of L. Gets $45,000 For Aid In Curriculum Development

Continuing development of the new curriculum at the University of Louisville School of Medicine will receive financial aid in the form of a three-year, $45,000 grant from the National Fund for Medical Education, according to John W. Brown, Ph.D., new assistant medical dean in charge of curriculum and graduate studies.

The curriculum study was begun in 1958, and was launched in September, 1963.

Studies for the complete revision of the curriculum were begun in 1958, and the program launched in September, 1963. The program, which is to progress in stages ,will begin its second year this fall with the Sophomore class.

In another grant announced at the same time, the pediatrics department received $21,000 from the National Foundation for the establishment of a birth-defects treatment center at Childrens' Hospital. The grant, which is designated for the first year of the center's operation, will be used for staff salaries.

Additional Funds Received

Other monies received for use at the medical school include: $20,000 from the Kentucky Division of the American Cancer Society for use at the Cancer Research and Treatment Center; $4,500 from the Younger Woman's Club of Louisville for the kidney research fund in the department of medicine; $4,000 from Kimberly-Clark Corporation to the pediatrics department; and $3,600 from the Louisville Tuberculosis Association for a fellowship in pulmonary diseases.

Kimberly-Clark Corporation also assigned a second grant of $1,495 for research. Also accepted were: $1,400 from Texas Pharmaceutical Company to the department of medicine, and $1,100 from the Honorable Order of Kentucky Colonels for medical scholarships.

Staff Changes Announced

The Board of Trustees of U. of L. have announced the following staff and faculty changes and appointments in the School of Medicine:

Department of Medicine: Alan M. Bornstein, M.D., clinical instructor; Marie M. Keeling, M.D., instructor in hematology; David Weinstein, M.D., instructor in neurology; Carl B. Rankin, M.D., clinical instructor; Dominick E. Gentile, instructor; R. Dietz Wolfe, assistant clinical professor; C. B. Yap, M.D., instructor.

In other changes announced, Mrs. Ruth Atwood and Mrs. Frances G. Livingston have been named instructors in medical bibliography; Rudy Kovachevich, M.D., instructor in pathology; Joseph F. Genaro, Jr., M.D., associate professor of anatomy; R. J. Kaiser, instructor of ophthalmology; Leonard E. Reisman, M.D., assistant professor of pediatrics; Paul B. Johnson, associate professor of microbiology; and Mohammad Atik, M.D., associate professor of surgery.

A. B. Mullen has been promoted to associate clinical professor of medicine; and William H. Anderson, to chief of section on pulmonary diseases. Marvin Murray, M.D. and James E. Parker were promoted to associate professors of pathology.

William H. Marshall, M.D., assistant professor of surgery, and Kemal Onen, M.D., instructor in medicine, have resigned.





TAKE 5

...and find that a TB screening test has never been quite so easy

SWAB THE ARM— UNCAP A TINE TEST— PRESS—DISCARD THAT'S ALL THERE IS TO IT.

Comparable to the Mantoux in accuracy and sensitivity, the TUBERCULIN, TINE TEST is now available in plastic-capped units uniquely suited to general practice needs. They are so simple to use that you can test every patient with ease. Since it requires no refrigeration, the new package of five Tine Test units can stand on any convenient table in your examining rooms, ready for routine use. Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis.

available as the new individually-capped unit, boxes of 5, or in cartons of 25

TUBERCULIN, TINE TEST

(Rosenthal) Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle

7899-4

'Battered Child' Law to Protect Children from Physical Abuse

A statute enacted by the 1964 Kentucky General Assembly, requiring physicians to report cases in which children have been injured by means other than accidental, became effective June 19. This refers to children whom the physician knows or suspects to have been physically abused.

Pertinent passages in the law state: "Any physician, osteopathic physician, or other person having reasonable cause to suspect that a child under the age of 18 brought to his attention has had serious physical injury . . . . inflicted upon him other than by accidental means by a parent or other person responsible for his care, shall report or cause reports to be made (to the appropriate police authority) . . . . Anyone acting . . . . pursuant to this Act shall have immunity from all liability, civil or criminal . . . ."

According to Richard J. Clendenen, Ph.D., commissioner of the Kentucky Department of Child Welfare, the Kentucky Act follows the outline of a model law for states developed after interest was aroused by a symposium on "The Battered Child" at the meeting of the American Academy of Pediatrics in October, 1961.

It is estimated that there are some 10,000 cases of battered children each year in the United States, with a fatality rate of one in four. In order to protect such children, the Kentucky Law requires that copies of reports made in these instances go to the Kentucky Department of Child Welfare for investigation and "to bring said cases under the purview of the county court sitting in juvenile session".

Letter to Young Physician Offers Ageless Advice

The following letter is published as it was originally written to Uberto Wright McPherson, M.D., a Kentucky physician who graduated from the Louisville School of Medicine in 1898 and practiced at Sulphur Wells, Horse Cave, and later in Louisville.

The original of the letter, written by W. B. Jones, his grandfather, also a physician, is in the possession of Mrs. Eugenia McPherson Dickey of Louisville, Doctor McPherson's daughter. The letter appears below without corrections or alterations.

Lincoln, Ill's 31 Jany. 1898

My Dear Grandson,

Replying to your card of inquiry received this morning, I inclose copies of portions of my Family Register which will furnish a portion of the information you desire.

Your grandmother died of fever. The physicians pronounced it a severe type of malarial fever, in which her entire nervous system was involved.

I am at present in reasonably fair health. Have recently had quite a severe cold, somewhat on the order of grippe. Now substantially recovered. Are having so far a rather disagreeable, though not for this country, a very cold winter, considerable snow, and damp weather.

Have no news of a special character. The general news you of course learn from the newspapers.

I hope you will be successful and useful in your profession.

An important matter is to be always a student, continully learning. The science of Pathology; the course, nature and cure of diseases, was little known fifty years ago, as compared with the results of that fifty years progress to the present time. The physician of twenty-five years ago would be wofully deficient to day if he had learned nothing new during that 25 years. Dr. Hadgen, Professor in the St. Louis Medical College, had no superior in his profession when he died some 15 or 18 years ago. Could he come to life now and remember all that he knew when he died, he would lack much of being abreast of the times as they now exist.

There can be no doubt that people have for thousands of years, been dying of diseases wholly misunderstood and miscomprehended by the best physicians. The main point is to forget nothing, and be continually learning.

Kind regards to your wife as well as yourself.

Your Grand Pa,

W. B. Jones

Dr. Uhde is Ky. Chairman of DRF

George I. Uhde, M.D., Louisville otoloryngologist, has been appointed Kentucky State Chairman of the national Deafness Research Foundation, it was recently announced. He is an assistant professor and chairman of the section on otorhinolaryngology at the University of Louisville.

Doctor Uhde will act as spokesman for DRF at state and regional medical meetings, serve as liaison between the Foundation, the medical profession and the general public, and reply to inquiries about medical aspects of ear disorders addressed to the Foundation by people in Kentucky.

Wholesale Drugs

and

Physicians Supplies

JOHN T. VIE CO., INC.

WH 4-7784 New Albany, Ind.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

IN KENTUCKY

JULY

22-23	Cumberland Valley Seminar, KAGP, S.E. Kentucky Baptist Hospital, Corbin, Ky.
25-26	Community Disaster Planning, AMA Committee on Disaster Medical Care, Stouffer's Inn, Louisville, Ky.
30	West Kentucky Seminar, KAGP, Irvin Cobb Hotel, Paducah, Ky.

AUGUST

13	KAGP Seminar, Bardstown, Ky.
29-30	Bluegrass Seminar, KAGP, Lexington, Ky.

SEPTEMBER

12	Internal Medicine, American College of Physicians, Joint Meeting of Kentucky and Tennessee, Louisville, Ky.
29-Oct. 1	KSMA ANNUAL MEETING, Convention Center, Louisville, Ky.

OCTOBER

8	KAGP Seminar, Maysville, Kentucky
26-27	American Association for Automotive Medicine, Stouffer's Inn, Louisville, Kentucky

SURROUNDING STATES

JULY

10-11	18th Annual Rocky Mountain Cancer Conference, Denver, Colo.
24	American Diabetes Association, Royal York Hotel, Toronto

AUGUST

24-27	American Hospital Association, Palmer House, Chicago, Ill.
24-27	American Academy of Physical Medicine and Rehabilitation, Statler-Hilton, Boston, Mass.
25-28	American Association of Blood Banks, Washington, D.C.

SEPTEMBER

9-12	International College of Surgeons, Chicago, Ill.
10	10th Annual Medical Symposium, Cabell County Medical Society, Frederick Hotel, Huntington, W. Va.
10-12	American Association of Obstetricians and Gynecologists, Homestead, Hot Springs, Virginia
17-19	5th Annual Cancer Conference, American Cancer Society and National Cancer Institute, Philadelphia, Pa.
26-27	Congress on Occupational Health, AMA, Rice Hotel, Houston, Tex.

OCTOBER

5-9	American College of Surgeons, Conrad Hilton Hotel, Chicago, Ill.
5-9	American Association of Public Health Physicians, New York Hilton, New York, New York
8-10	American College of Physicians, Hotel Biltmore, Los Angeles, Calif.
10-14	American Society of Anesthesiologists, Bal Harbour, Florida
17-20	College of American Pathologists, Americana Hotel, Bal Harbour, Fla.
18-21	American College of Gastroenterology, Roosevelt Hotel, New York, N.Y.
18-23	American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Ill.
23-24	American Heart Association, Chalfonte-Haddon Hall, Atlantic City, New Jersey
24	American Academy of Pediatrics, New York Hilton, New York, N.Y.
28-30	American Cancer Society, Biltmore Hotel, New York, New York

NOVEMBER

16-19	Southern Medical Association, Memphis, Tennessee
20-21	American Psychiatric Association, Bellevue Stratford Hotel, Philadelphia, Pennsylvania
28-29	American College of Chest Physicians, Interim Meeting, Miami Beach, Florida
29-Dec. 2	AMA Clinical Meeting, Miami Beach, Florida

News Items

Donald Leigh Oberlin, M.D., former Glasgow Radiologist, is now in practice at Irving, Texas, according to an announcement from the Texas State Medical Association. Doctor Oberlin graduated in 1957 from the University of Texas Southwestern Medical School in Dallas.

Astra U. Kidd, M.D., is the new county health officer in Hardinsburg. A graduate of the University of Louisville in 1962, she serves Breckinridge, Hancock, and Meade Counties. Doctor Kidd took her internship at the University of Kentucky.

Edward J. Broaddus, M.D., formerly of Beattyville, Ky., has started practice in Lawrence, Mass., and is a new member of the Massachusetts Medical Society.

Paul F. Rizk, M.D., has resumed medical practice in Grayson. He is in the office of the late B. B. Baker, M.D.

Margaret Livengood, M.D., has left her post as Health Officer for Bell and Marlan Counties, and has accepted a position with the maternal and child health program in southeastern Kentucky under the direction of the division of Maternal and Child Health of the Kentucky State Health Department.

Clarence J. Mills, M.D., Clinton, has announced the closing of his office in that city and the resumption of his practice at Reidland in McCracken County. Doctor Mills graduated from the University of Louisville School of Medicine in 1961, and has practiced in Clinton since the completion of his internship.

Joseph Dew, M.D., formerly of Hardinsburg, has opened an office for the general practice of medicine at Vine Grove. Doctor Dew graduated from the University of Louisville School of Medicine in 1962.

J. Keith Linville, M.D., has entered practice in Central City, and will occupy the office of **John P. Walton, M.D.,** now retired, a recipient, in 1962, of the KSMA General Practitioner of the Year award. Doctor Linville, a 1962 graduate of the University of Louisville School of Medicine, interned and completed a year of medical residency at Louisville General Hospital.

Wallace R. Alexander, M.D., Madisonville, has become associated with the Trover Clinic in that city, where he will limit his practice to internal medicine. Doctor Alexander, a 1954 graduate of the University of Tennessee School of Medicine, interned at Baroness Erlanger Hospital in Chattanooga and completed his residency while serving in the U.S. Air Force.

Darran P. Huggins, M.D., is now practicing in association with **William W. Wainer, M.D.,** in Providence. A 1963 graduate of the University of Iowa Medical School, he interned at Riverside Hospital, Toledo, Ohio.

Richard H. White, M.D., is the new Fulton County health director. He succeeds **J. C. Morrison, M.D.,** who resigned recently.

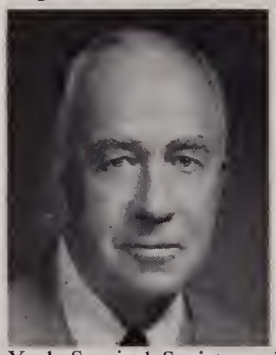
J. Edmundo Esteves, M.D., Warsaw, has been appointed honorary vice-consul of Ecuador for Greater Cincinnati.

Two Louisville pediatricians have received separate $12,000 grants from the National Institute of Mental Health to take a year's training in child psychiatry. **Grace M. James, M.D.,** will take hers at Creedmore State Hospital, New York City, and **Elliott Podoll, M.D.,** will train at Boston General Hospital.

Robert P. Schiavone, M.D., Louisville, has announced the opening of his office in that city, where he will practice general medicine. Doctor Schiavone, who until recently was in practice in Owenton, is a 1961 graduate of the University of Louisville School of Medicine. He interned at Marion County General Hospital, Indianapolis.

Dr. Cave, Paducah Native, Dies

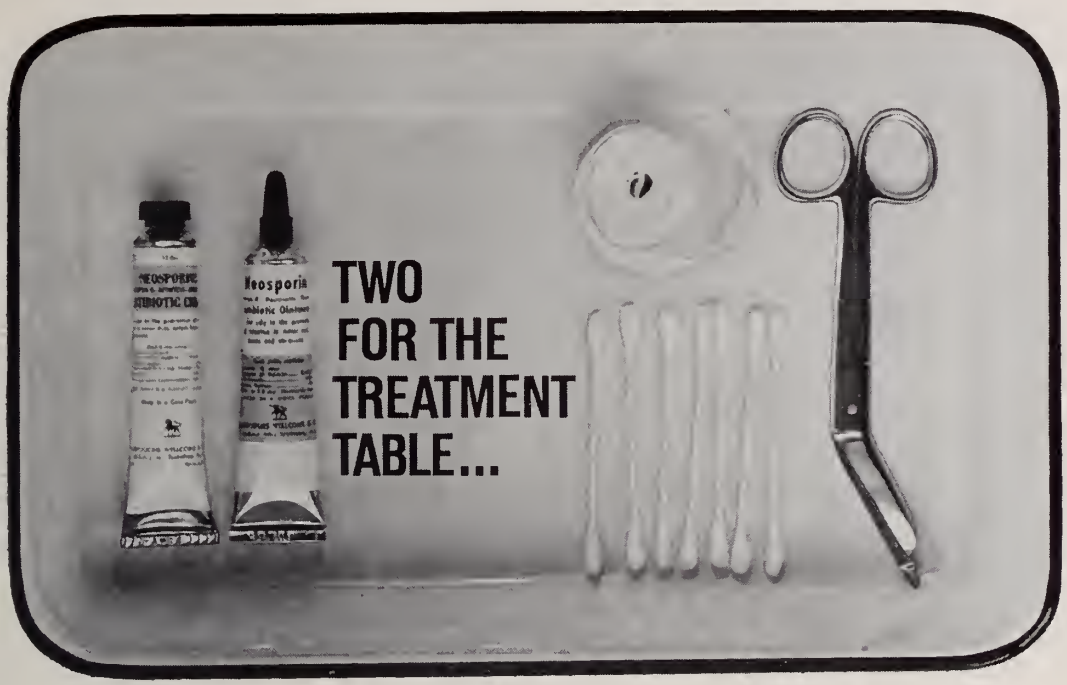
Henry W. Cave, M.D., 76, eminent New York surgeon and a native of Paducah, died June 20 after a long illness. Doctor Cave, who had graduated from Centre College in 1909, was awarded his M.D. at Johns Hopkins University School of Medicine in 1913.



A former faculty member at Columbia University College of Physicians and Surgeons, Doctor Cave had been president of the New York Surgical Society and a vice-president and later trustee of the New York Academy of Medicine. He was an honorory member of the Royal College of Surgeons in Edinburg, Scotland, and of the Royal Society of Medicine in London. He was a KSMA Centennial Speaker in 1951 and has also addressed other medical groups in the state, including the Kentucky Surgical Society, on a number of occasions.

GENERAL PRACTITIONER needed for community clinic, completely furnished in a town in Northwestern North Dakota which has a large trade area.

Write: JKSMA 3532 Janet Avenue
Louisville, Ky. 40205



Both the Cream and Ointment rarely sensitize and are bactericidal to virtually all gram-positive and gram-negative organisms found topically, including Pseudomonas aeruginosa and Staphylococcus aureus.

Indications: Wherever infection occurs and is accessible for topical therapy.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

'NEOSPORIN'® brand
POLYMYXIN B / NEOMYCIN / GRAMICIDIN
ANTIBIOTIC CREAM

Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Gramicidin 0.25 mg.

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, distilled water, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax and 0.25% methylparaben as preservative.

*U.S. Patent Nos. 2,565,057-2,695,261

Available: In 15 Gm. tubes.

'NEOSPORIN'® brand
POLYMYXIN B / BACITRACIN / NEOMYCIN
ANTIBIOTIC OINTMENT

Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base).

Available: Tubes of 1 oz., ½ oz. and ⅛ oz.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

County Society Reports

Daviess

William W. Hall, M.D., Owensboro, took office June 15 as 1964-65 president of the Daviess County Medical Society. Also assuming executive duties at that time were Fred C. Reynolds, M.D., new vice-president, and R. J. Phillips, Jr., M.D., secretary-treasurer.

Delegates for the coming year will be J. S. Oldham, M.D., Doctor Hall, and B. H. Warren, M.D., Alternate delegates are John Dixon, M.D., and Guy Morford, M.D. All the officers are from Owensboro.

Henderson

George A. Buckmaster, M.D., has been chosen president of the Henderson County Medical Society for 1964. Doctor Buckmaster will be assisted in his duties by John Marchand, M.D., vice-president, and John L. Jenkins, M.D., secretary-treasurer. Julian B. Cole, M.D., will be the delegate to the Kentucky State Medical Association, and Walter L. O'Nan, M.D., alternate delegate. All are from Henderson.

Marion

Eli J. George, M.D., Lebanon, is serving as 1964 president of the Marion County Medical Society, according to a recent announcement. Secretary-treasurer of the Society is Duncan G. Salot, M.D., Lebanon. David Drye, M.D., Bradfordsville, will serve as delegate to the Kentucky State Medical Association.

McCreary

H. A. Perry, M.D., Sterns, is president of the McCreary County Medical Society. M. A. Winchester, M.D., Whitley City, serves the group as secretary. Doctors Perry and Winchester also are KSMA Delegate and alternate, respectively.

Muhlenberg

The June 1 meeting of the Society received a report on the first year of operations of the Greenville School of Practical Nursing. Mrs. Nadine Turner, Director of Nursing at the local hospital, reported that the 18 members of the graduating class had been recruited from four counties.

Members of the society were instrumental in establishing the school, and provide bedside clinics and maintain a pediatrics clinic to help provide the material necessary for a satisfactory course. Because of forty applications received for the next course beginning June 22nd, the next class is being enlarged to twenty. The Society authorized prizes of $25, $15 and $5 for awards to the top three graduates.

At the request of the Woman's Auxiliary, the Society broadened the Nurse Scholarship Fund to provide scholarships for the education of any ancillary personnel.

In the clinical portion of the program, G. L. Simpson, M.D., Greenville, presented a paper on "Intervertebral Disc Infections," including case reports.

Owen

Maurice Bowling, M.D., Owenton, has been elected to serve a two-year term as president of the Owen County Medical Society. O. A. Cull, M.D., also of Owenton, is secretary-treasurer. Doctor Cull will serve as delegate to KSMA, and Doctor Bowling as alternate delegate.

Webster

Paul Taylor, M.D., Providence, took office recently as 1964-65 president of the Webster County Medical Society. Assisting Doctor Taylor in his duties will be James Gamble, M.D., Providence, new secretary of the Society. John Logan, M.D., Cebree, will serve as delegate to the KSMA, and W. W. Wainer, M.D., Providence, as alternate.

M. Earl McRae, M.D., has begun practice at Bardwell, where he will limit his practice to general medicine. Doctor McRae, a 1941 graduate of the University of Tennessee School of Medicine, served in the U.S. Army Medical Corps during World War II, and from 1946 until 1963 practiced in Laurel, Miss.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

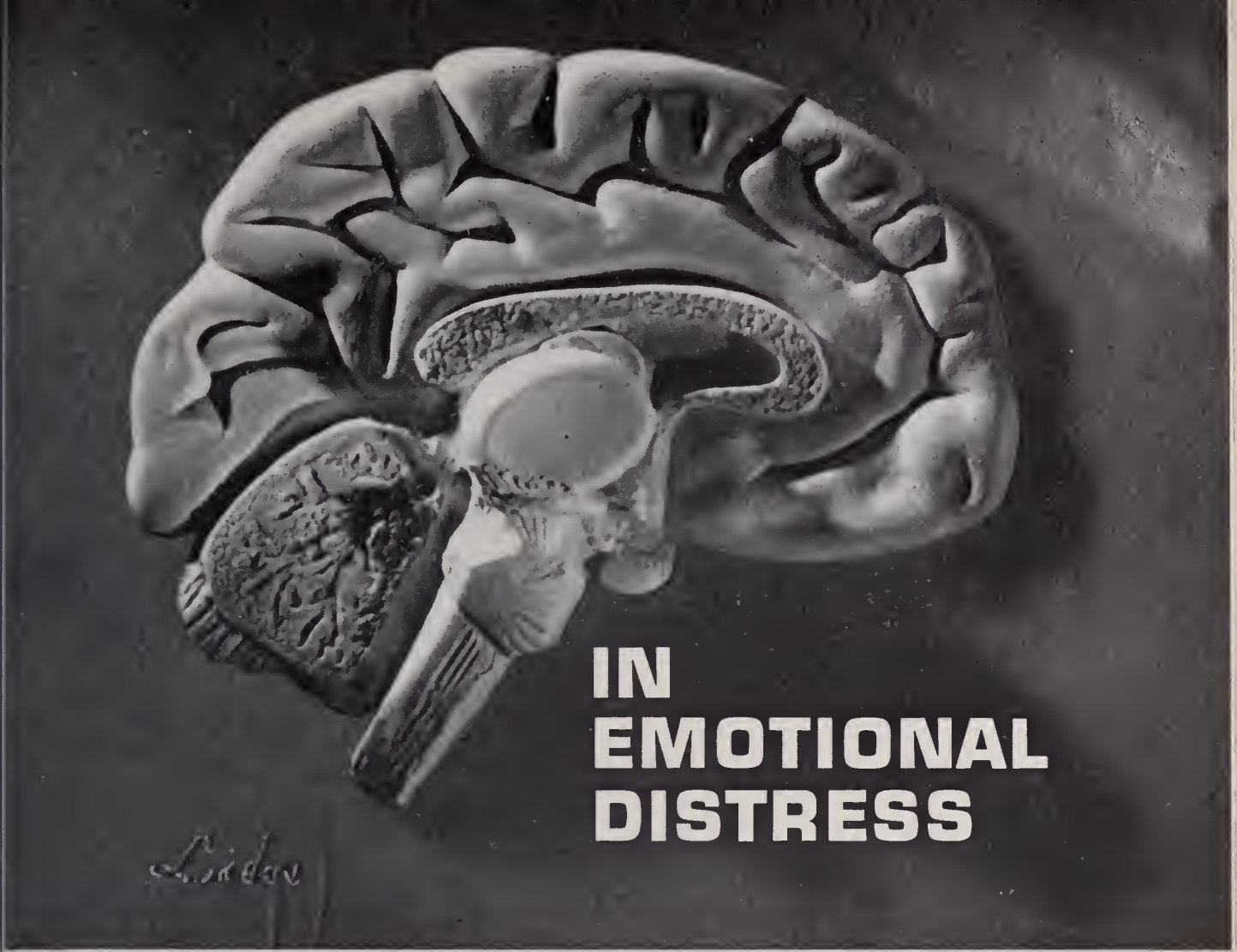
- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospitol Association. Licensed by the Department of Public Health, State of Illinois.



RELIEVES ANXIETY, APPREHENSION AND TENSION...



All day long

. . . keeps the patient calm, and the mind clear.



All night too

. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400

(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CME-1969

WALLACE LABORATORIES *Cranbury, N. J.*

IN THE BOOKS

PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION, Fourth Edition: by John J. Hanlon, M.D., M.P.H. Published by The C. V. Mosby Company, St. Louis, 1964; 694 pages; price, $11.50.

With unwarranted modesty Doctor Hanlon proposed, in the preface to the first edition of this very useful book, that he would try to develop an understanding of fundamental principles and to compile a modicum of information for the novice in public health administration. Certainly he did these things.

But the book is a guide for more than the neophyte. It is a comfort to the established health worker, a source of sound philosophy for the thinking health planner, and a reference without equal. It has also the unique characteristic of being the work of a single excellent medical educator and public health administrator. One does not experience in reading it the frustrating and distracting change of pace and style that is characteristic of some other texts. Despite the frequent quotes from other masters in the field, this book is "John Hanlon" from cover to cover.

This Fourth Edition has faced the challenge of violent change by attempting to modernize some concepts and some data. Also, and this in itself makes the volume delightfully different, behavioral science and related subjects are treated in depth and with wisdom.

The medical public health practitioner of any age or extent of experience should have this book. It covers those principles most frequently and most intimately involved in health officer or health department success or failure. The private practitioner of medicine or medical education who reads it will have a better understanding of the health problems and attempts at their solution by health agencies and health officials.

CHARLES F. BLANKENSHIP, M.D.

PEDIATRIC THERAPY: edited by Harry C. Shirkey, M.D. Published by the C. V. Mosby Company, St. Louis; 1964; 1144 pages; price, $16.50.

This volume, compiled with the aid of 72 contributors, is practical one-volume treatise designed for all physicians who care for sick children. The first three parts—Drug Treatment, Treatment of Symptoms, and General Therapy—establishes its value and uniqueness as a Pediatric treatment manual. An example of the editor-author's practical approach is the forthright way in which he acknowledges and discusses the empiric body surface area calculation, but shows its usefulness in calculating dosages. Throughout the book there are frequent demonstrative photographs and useful tables. One could consider as bonuses the table of Drugs That Color The Urine and the succinct nutrition tables.

The organization of the remaining fifteen parts according to traditional groups of disorders and diseases makes it easy to find pertinent information when treating a patient. Each topic is usually introduced with a brief statement concerning the pathophysiology and expected positive laboratory data. Therapy is considered in the broad sense, and the instructions and suggestions that follow include specific therapy, supportive therapy and cautions. The book concludes with a Table of Dosages on colored paper that makes the section available for easy reference. Generic names, along with pertinent trade names, and the metric system are used.

The therapeutic g u i d a n c e presented is current, authoritative and provides sufficient information to organize a treatment regimen for a patient. The book fulfills an existing need and, sooner or later, will be found alongside your Physician's Desk Reference.

C. CHARLTON MABRY, M.D.

A SYNOPSIS OF GASTRONTEROLOGY: by G. N. Chandler, M. A., D. M., M. R. C. P. The Williams & Wilkins Co., Baltimore, exclusive U. S. afents, 1963; 192 pages; price, $7.00.

This book attempts to cover the field of gastroenterology in outline form in a scant 192 pages. Credit is given in the preface to three standard British textbooks on the subject. No references are included in the text. The reviewer feels that outlines of this type are only beneficial to those who make them.

The only beneficial use this book might have is for a general review of gastronenterology the night before state board examinations. The book is not recommended.

F. NORMAN VICKERS, M.D.

ELECTROCARDIOGRAPHIC NOTEBOOK, Second Edition: by M. Irene Ferrer, M.D. Published by Hoeber Medical Division, Harper and Row, New York, 1964; 112 pages; price, $2.75.

This short book is obviously designed for student reading. It makes no pretense of completely reviewing the field of electrocardiography but rather gives a compact summary of normal electrophysiology and normal and abnormal electrocardiography.

The book succeeds very well in its goal of simplicity and conciseness though one might question whether these goals are desirable in a field where knowledge of one's limitations is as important as knowledge of abnormal patterns. In some sections such as descriptions of axis deviation there is over-simplification to the point of inaccuracy. The book also leaves something to be desired in the lack of illustrations but this was apparently necessary in order to keep the book brief.

LEONARD LEIGHT, M.D.



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective **GERIATRIC** antiarthritic with

REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate-SF

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe
PABALATE-SODIUM FREE

In Memoriam

JOHN WILLIAM CONWAY, M.D.
Morganfield, Ky.
1872-1964

John William Conway, M.D., retired general practitioner, died at Our Lady of Mercy Hospital, Morganfield, on May 16. A graduate of the University of Louisville School of Medicine in 1898, he started practice in Morganfield in 1899. Doctor Conway, who was 91 at the time of his death, had practiced more than 60 years. He had been in practice until about two years ago, although his activity was curtailed somewhat in later years.

JOHN COULTER MORRISON, M.D.
Hickman, Ky.
1884 - 1964

John C. Morrison, M.D., 80, Hickman general practitioner, died June 10 in a Memphis hospital. Doctor Morrison, who graduated in 1908 from the Medical Department of Vanderbilt University, had practiced in Fulton County since 1921. He served for 40 years on the Fulton County Board of Health. Doctor Morrison had been semi-retired since 1962.

MACK WHITIS, M.D.
East Bernstadt, Ky.
1882 - 1964

Mack Whitis, M.D., 81, retired general practitioner of Laurel County, died May 24 of a heart attack. A 1908 graduate of the Hospital College of Medicine in Louisville, he had practiced in Laurel County since that time. Doctor Whitis had been active in the affairs of organized medicine and in church work.

EDWARD PUTNEY GUERRANT, M.D.
Winchester, Ky.
1883 - 1964

Edward P. Guerrant, M.D., 81, a Presbyterian medical missionary and founder of the Guerrant Clinic and Hospital in Winchester, died June 17 after a long illness. A surgeon, he retired from practice in 1962. Doctor Guerrant was a graduate of the Medical Department of Tulane University in 1913.

CHARLES C. BURTON, M.D.
West Liberty, Ky.
1882-1964

Charles C. Burton, M.D., 81, retired West Liberty general practitioner, died May 31. Doctor Burton, who graduated in 1907 from the Hospital College of Medicine in Louisville, had practiced in Morgan County since that time.

KSMA Council and Committee Reports

Golf Committee

Kenton D. Leatherman, M.D., Louisville, Chairman

KSMA Headquarters **May 28, 1964**

The Golf Committee met on May 28 and finalized the plans for the 1964 KSMGA Golf Tournament which will be held Monday, September 28 at the Big Springs Country Club in Louisville.

The committee members voted that the Tournament will be a one-day affair and that all those who wish to participate must submit their applications and dues by September 1, 1964. A number of trophies and prizes were approved for the Tournament. It was taken by common consent to use the Banker's System once again for determining handicaps and to conduct the publicity similar to that in the past years.

Council on Medical Education And Hospitals

Walter S. Coe, M.D., Louisville, Chairman

KSMA Headquarters **June 4, 1964**

The Council on Medical Education and Hospitals recently held their third and final meeting of this Associational year. The main item of business before the council was to receive and act on the final reports of the five KSMA committees serving under the council.

The chairman announced during the meeting that a questionnaire on Medical Education would be distributed to all Kentucky physicians during June. The final results of the questionnaire will probably not be available for the 1964 Annual Meeting.

Recipients of the KSMA Scientific Achievement Award for one individual at each of Kentucky's two medical schools were also selected. The awards will be presented September 30 during the Annual Meeting. The council recommended to the Board of Trustees that they encourage the Kentucky State Board of Health to include the specialty of each physician in future printings of the Kentucky Medical Directory which is published annually by the State Board of Health.

FOR RENT:

Fully equipped and handsomely furnished office (1000 square feet) in the two-year old Southern Parkway Medical Center, Louisville, with 5 MD's, 1 dentist, 1 orthodontist, full X-Ray Department, Diagnostic Laboratory and Apothecary. Office contains files of an extensive and well established practice. Owner leaving to do a residency.

Tel. 361-2414 893-3112
895-0596 893-7093



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK®

NEW MEN'S SHOP



. . . in our NEW SOUTHERN OPTICAL BUILDING, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

GUILD OPTICIANS Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th (Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

A symposium on "The Skin and Systemic Disease" will be featured at the 69th annual meeting of the National Medical Association in Washington, D.C., on August 6. Held in the Statler-Hilton, the symposium will be sponsored jointly by the NMA's combined sections on dermatology and medicine and the AMA's committee on cutaneous health and cosmetics.

"Recent Advances in the Control of Respiratory Virus Diseases, Including the Exanthemata" is the subject of the Caleb Fiske Prize Essay Contest of the Rhode Island Medical Society. Essays must be typewritten, double spaced, should not exceed 10,000 words, and must be submitted by December 11, 1964. A cash prize of $500 is offered. For complete information write: Rhode Island Medical Society, 106 Francis St., Providence, R.I. 02903.

The 12th annual meeting of the Tennessee Valley Medical Assembly is scheduled for September 28 and 29 at the Tivoli Theater in Chattanooga. It is sponsored by the Chattanooga and Hamilton County Medical Society, Inc.

Essentially the state journal is the tie that binds. It is the visible thread that runs from one corner of the state to the other. It is the only such ligature. It is an opinion m e d i u m for legislative, medicolegal, organizational, economic, and administrative topics. It is the officers' way of reaching the membership; and it is the members' way of letting the officers know what they—the members—think. It is a portable bulletin board for telling the readers what's going on. Without this liaison among members, their esprit-de-corps, their feeling of professional identification, and their sense of organizational identity might well atrophy.—Henry A. Davidson, M.D., in *Journal of the Medical Society of New Jersey*, 61:1 (Jan.) 1964.

David McL. Greeley, M.D., medical director of the Daniel Boone Clinic and former chief of clinical services for Harlan Memorial Hospital, has announced that he will become associate director of the Educational Council for Foreign Medical Graduates at Evanston, Ill., effective June 1.

MT. HOLLY
NURSING HOME

A Nursing Home with Hospital Standards



- *24 Hour Personal, Medical and Nursing Care supplemented by Closed Circuit Television.*
- *Balanced and Therapeutic Diets.*
- *Facilities for Orthopedic, Geriatic and Medical Patients.*
- *Leisure time activities.*

MT. HOLLY NURSING HOME

OFF BROWNSBORO ROAD 897 - 1646

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrotor

MARGARET KELLY, R. N., Director of Nurses

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lossiter, Representotive
203 Porkside Building, 4140 Shelbyville Rood, Louisville 7
Moiling Address: P.O. 8ox 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884

PUBLIC HEALTH PAGE

Medicial Attitudes in the Treatment of Alcoholics*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health, Commonwealth of Kentucky

A PATIENT at one of the alcoholism units in a state hospital recently said, "I have been in and out of hospitals for the past six years and have talked to at least nine or ten doctors. Why didn't any of them tell me I was an alcoholic and that all those illnesses were due to drinking?" Another patient told a counselor, "A few years ago my husband started telling me I was an alcoholic and that I needed help. I finally stopped him by getting my doctor to call and tell him it wasn't true."

The attorney who asked that question was bitter, the housewife was amused, but they both pointed out the fact that many alcoholics are totally unaware that they are victims of the disease and continue for years thinking of themselves as merely heavy drinkers who have had a lot of bad luck in life.

In Kentucky today one of every 20 to 25 adults has a problem with alcohol, and cirrhosis of the liver is the 11th casue of death. The laws of probability dictate that the average physician sees an alcoholic patient at least once a day in general practice. Yet a diagnosis of alcoholism is rare except for the express purpose of getting a person into one of the alcoholism wards at state hospitals.

Dr. Richard C. Bates, writing in *The Journal of the Michigan State Medical Society* (Oct. 1963), points out some of the reasons why doctors are reluctant to make a diagnosis of alcoholism and then goes on to list some of the clues to such a diagnosis. Drawing on his experience with more than 400 patients from all walks of life admitted to the alcoholism unit at E. W. Sparrow Hospital in Lansing, Dr. Bates has compiled a list of social and physical factors which suggest alcoholism even though the patient comes to the office for some other complaint.

"Alcoholics as a rule are depressed, tense, self-centered, hypochondriacal, impulsive, hostile, and immature," he says. "The present illness will usually display many of these traits and the family history may be revealing in that, if your patient is a child or sibling of an alcoholic or cirrhotic patient, he has a 50-50 chance of alcoholism himself."

He also mentions as highly suspect the patient without a high school education, a person who changes jobs frequently, a person who holds a job well below his obvious education and ability, the execuive who takes an inferior job with a smaller company, self-employed men who go into bankruptcy, and the apparently healthy man who is unemployed.

"On the physical examination," Dr. Bates says, "look first for shabbiness, poor hygine, and poverty below a man's position, education, and social background. A red face and acne rosacea are familiar signs even to the layman. Alcohol is more vasodilating to the alcoholic than to the social drinker. Periorbital edema, bags under the eyes, scleral edema and nystagmus on lateral gaze all suggest a hangover. Coarse tremor of the outstretched hands occurred in 80% of our patients.

"If a palpable non-tender liver can't be explained by cholecystitis, diabetes, emphysema or obesity, it strongly suggests alcoholism—55% of our patients had a palpably enlarged liver."

Dr. Bates also mentions the person with a bruise or other injury several hours or days old who gives a flimsy excuse for not coming earlier. He suggests that this patient didn't want to be seen drunk or didn't know he was injured until the alcohol wore off.

The article did not make a case for early diagnosis but it might be significant to report here the results of a recent study made by the State Health Department. The median age of persons being arrested for alcohol-related offenses in Louisville is 32. The median age of male patients admitted to the alcoholism ward at Western State Hospital is 43. This represents an 11 year period between first real trouble and severe deterioration—a period during which a person could be helped if he had been diagnosed and brought face-to-face with the real cause of his problem.

In his summary Dr. Bates says, "Whether or not a physician is interested in alcoholism he cannot afford to shut his eyes to a condition that afflicts 5% of our population and shortens life expectancy by 15 years. If he makes the diagnosis a number of sources are available to him for help. In our experience if a patient who has the disease is apprised of the diagnosis and guided to help by an understanding physician he and his family will be eternally grateful and the physician will reap as much self-satisfaction as though he had detected an early cancer."

This article was prepared from literature by Omar L. Greeman, B.J., M.S.P.H., Acting Director, Alcoholism Program, Kentucky State Health Department, 275 East Main Street, Frankfort, Kentucky

U. L. Professors Honored

Nine faculty members of the University of Louisville School of Medicine were recognized at the University's June 7 Commencement exercises as having served the school for 25 years.

Named were: William C. Buschemeyer, M.D., Jack Chumley, M.D., and George W. Pedigo, M.D., all associate professors of medicine; Gradie R. Rowntree, M.D., professor of occupational medicine; Edward Cadden, M.D., instructor in obstetrics and gynecology; Edward E. Landis, M.D., professor of psychiatry; and Robert Lich, M.D., professor and chairman of the section on urology.

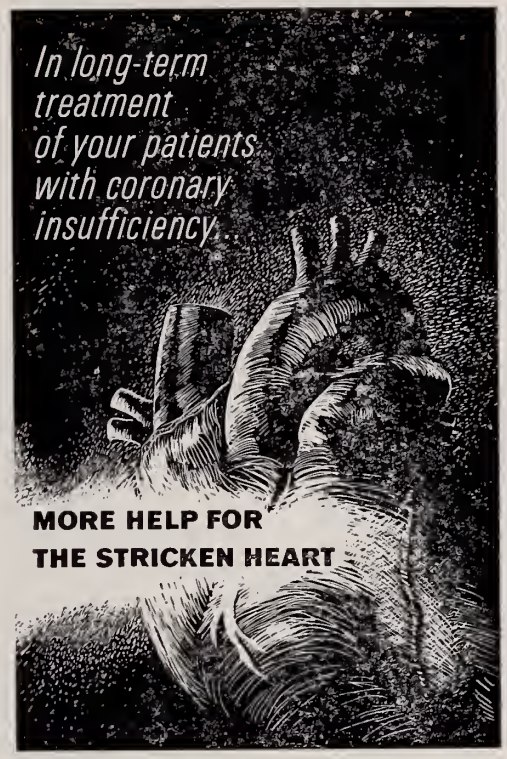
Another approach, and the one now most fashionable, is to call for "more adequate" testing of drugs in animals and humans. Yet, when a drug given to pregnant rabbits results in birth of malformed offspring, it may be unreasonable to rule it off the market. For, under such a policy, the sale of insulin, streptomycine, penicillin, or cortisone might have been forbidden. A recent editiorial in *The Lancet* calls attention to this point. Under the latest F.D.A. rulings, aspirin might not be allowed on the market!—J. F. Lucey, M.D., in *Pediatrics,* Dec. 1963.

STAFF PHYSICIANS FOR FULL - TIME APPOINTMENT

VETERANS ADMINISTRATION HOSPITAL

LEXINGTON, KENTUCKY

There are openings for several full-time staff Physicians at this predominantly psychiatric hospital with expanding medical, surgical and geriatric services. Salary $9980 to $18,240 depending on qualifications; liberal fringe benefits. Excellent cultural and educational opportunities in community. Visit for personal interview can be arranged at our expense. Moving costs to Lexington will be paid. Write or call Director, V. A. Hospital, Lexington, Kentucky.



- PETN (pentaerythritol tetranitrate) to increase oxygen supply
- plus meprobamate to decrease anxiety and tension

Unlike phenobarbital, meprobamate is *not* cumulative and does *not* cause depression.

Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Precautions: Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Contraindications: Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* Dosage: 1 to 2 tablets, *before meals* and at bedtime. Individualization required. Supplied: Bottles of 50 tablets.

CML-1055

MILTRATE®

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS — 1963-1964

GEORGE P. ARCHER, Prestonsburg ..... President
DELMAS M. CLARDY, Hopkinsville ..... President-Elect
DAVID M. COX, Louisville ..... Immediate Past President
CARLISLE MORSE, Louisville ..... Vice President (Central)
CARL C. COOPER, Bedford ..... Vice President (Eastern)
JOHN DICKINSON, Glasgow ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, Corbin ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
DOUGLAS E. SCOTT, Lexington ..... Chairman of the Board of Trustees
GABE A. PAYNE, JR., Hopkinsville ..... Vice Chairman of the Board of Trustees

DELEGATES TO THE A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

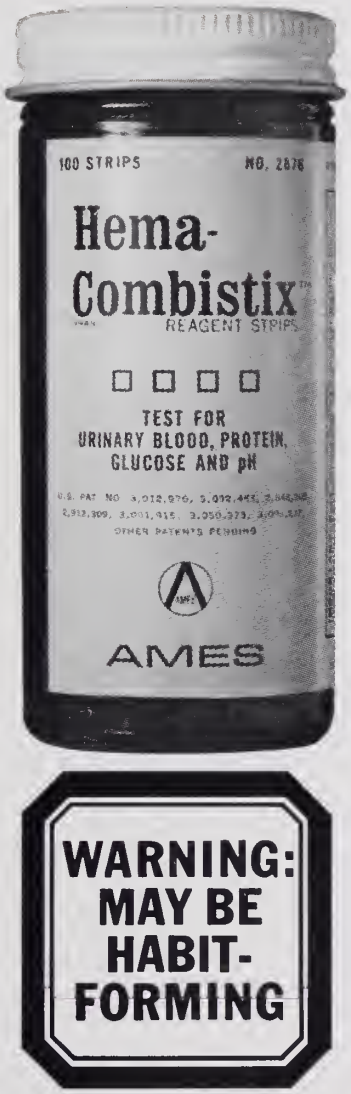
BOARD OF TRUSTEES

First District ..... O. LEON HIGDON, 2515 Broadway, Paducah 1965
Second District ..... HOWELL J. DAVIS, 330½ Allen Street, Owensboro 1964
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville (serving interim term) 1964
Eighth District ..... DON JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1964
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1964
Eleventh District ..... HUBERT C. JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... CLYDE C. SPARKS, Mayo Arcade, Ashland 1964
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

BUYERS GUIDE

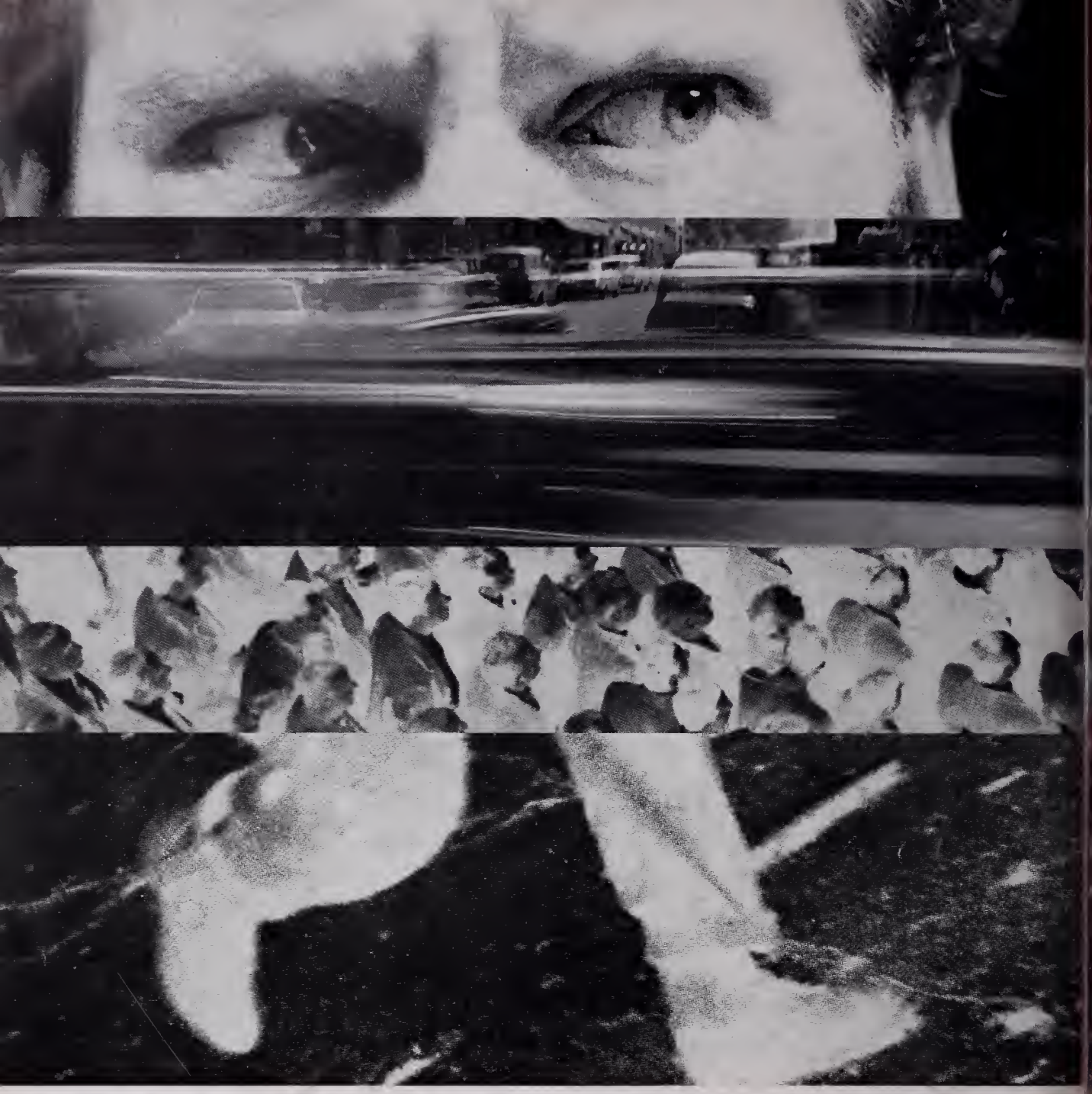
JOURNAL OF THE KSMA BUYERS GUIDE FOR JUNE, 1964

Ames Company 565
Burroughs Wellcome 546-553
Coco-Colo Company 559
E. L. Dennis, M.D. 558
Geigy Phormoceuticals 506
Glenbrook Loboratories 501
Journol of KSMA (Blind ad) 552
Wm. Kendrick Jewelers, Inc. 545
The Keeley Institute 554
Lederle Loborotories 497-508-509-549
Eli Lilly & Company 510
Medicol Protective Company 561
Mt. Holly Nursing Home 560
New Castle Sanitarium 561
Emerson A. North Hospitol 543
Parke, Davis & Company 496
A. H. Robins Company 504-557
Roche Loborotories 566
G. D. Searle & Company 539
Smith Kline & French 505
Southern Optical Company 559
V. A. Hospital 563
John T. Vie Company, Inc. 550
Wallace Loborotories 502-503-541-547-555-563
Winthrop Loborotories 499



Once you have used **HEMA-COMBISTIX,**™ dip-and-read test for urinary blood, protein, glucose, and pH, it may become a habit to test every patient's urine routinely with this simple, convenient reagent strip. Most of the answers will be "negatives," but an unexpected "positive" may alert you to serious pathology even before related symptoms appear. The test takes only 60 seconds. As basic as the stethoscope...**HEMA-COMBISTIX** is a *good* habit to form. □ Ames Company, Inc., Elkhart, Indiana. 68764

AMES



for
The Age of
Anxiety

In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment.

Supplied—Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.

ROCHE

LIBRIUM®
(chlordiazepoxide HCl)

Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, N.J. 07110

AUGUST 1964 • VOLUME 62 • NUMBER 8

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



LIBRARY
COLLEGE
JUL 28 1965

In This Issue

Bilateral Symmetric Recession of the Horizontal Rectus Muscles
Charles A. Perera, M.D. 581

Out-Patient Treatment of Head and Neck Lesions
Andrew M. Moore, M.D. 587

Pathogenesis and Treatment of Septic Shock
Allan M. Lansing, M.D. 590

Paroxysmal Ventricular Fibrillation
William R. Gray, M.D. 596

Complete Contents on Page 570

KSMA Annual Meeting Sept. 29.—Oct. 1
Convention Center, Louisville



pollens in the grass...alas

Kapseals®
Benadryl®
(diphenhydramine hydrochloride)

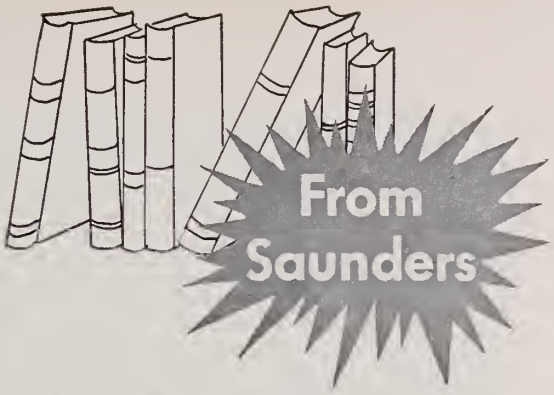
FOR EFFECTIVE CONTROL OF ALLERGIC SYMPTOMS—*Antihistaminic action* relieves nasal congestion, sneezing, lacrimation, and pruritus. *Antispasmodic action* relieves bronchial spasm. **Precautions:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers, if used with BENADRYL (diphenhydramine hydrochloride), should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENADRYL (diphenhydramine hydrochloride). BENADRYL (diphenhydramine hydrochloride) is supplied in several forms including Kapseals containing 50 mg. 39864

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Det. M

New—Moore's *Give and Take*

The development of tissue transplantation



This is the fascinating story of "new tissues for old"—its relatively brief but eventful history, the present status of the "art," and the promise of the future. Dr. Moore carries you along the devious trail of transplantation progress where you'll follow developments in autografts, homografts and heterografts—observe the intricacies involved in probing antigens, antibodies and immunity—learn of the early organ grafts with no suppression of immune reaction, then of the era of whole body irradiation and its eventual abandonment, and finally of today's successes with immuno-suppressant drugs. The heart of the text deals with the important events and patients in the 250-odd kidney transplants performed in the last decade. Five detailed and exciting case histories delineate turning points in transplantation progress. Intriguing topics, comments and anecdotes crowd the pages of this fascinating book. You'll find such subjects as: *the recognition by the immune system of its own proteins as harmless—the mechanism of immunologic memory—a tale of blood chimerism—the dilemma of tissue and organ donation, both ethical and legal.* Dr. Moore concludes with a succinct discussion of where transplantation is warranted or needed.

By Francis D. Moore, M.D., Mosely Professor of Surgery, Harvard Medical School; Surgeon-in-Chief, Peter Bent Brigham Hospital, Boston, Massachusetts. 182 pages, 5½" x 8½", illustrated. About $6.00. *New—Just Ready!*

New (8th) Edition—Nelson's *Textbook of Pediatrics*

Gives you an effective answer for every pediatric problem

Dr. Nelson and 81 eminent contributors cover the entire field of pediatrics in this *New (8th) Edition.* They discuss every aspect of child care, from the prenatal period through adolescence. They tell you how to keep the well child healthy, as well as how to diagnose and treat the myriad diseases of infancy and childhood. Disorders and malformations of each body system are covered in detail. All the childhood diseases are explicitly described, with authoritative discussions of etiology, epidemiology, pathogenesis, immunity, clinical manifestations, diagnosis, prognosis, prevention and treatment. This up-to-date revision is studded with newly developed diagnostic procedures, as well as both new and standard methods of prevention and treatment. You'll find information on *the problems involved in the battered-child syndrome—on newly discovered inborn errors of metabolism—on new theories of psychologic development.* Many chapters and sections are entirely new—*Pseudomonas and Other Gram-Negative Bacilli—Anonymous Mycobacterial Infections—Intestinal Malabsorption—Waardenburg's Syndrome—Interstitial Pulmonary Fibrosis.* Others are so extensively revised as to constitute virtually new material. Here is a book useful to any physician who ever treats infants or children.

Edited by Waldo E. Nelson, M.D., D.Sc., Professor of Pediatrics, Temple University School of Medicine; Medical Director of St. Christopher's Hospital for Children. With 81 distinguished contributors. About 1640 pages, 7" x 10", with 471 figures. About $18.00. *New (8th) Edition—Just Ready!*

New—Elliott's *Clinical Neurology*

Gives specific help on neurologic diagnosis and treatment

Here is a concise new work seasoned with clinical insight. The author skillfully presents crisp accounts of individual neurological diseases (both common and uncommon) plus principles and practice involved in neurological diagnosis. He provides pertinent anatomical, physiological, and neurochemical background material, focusing on practical application. Important diagnostic features of each disease discussed are stressed and the diagnostic significance of individual symptoms and signs are clearly spelled out. Among the many features of this new text you'll find: Helpful information on differential diagnosis of diseases exhibiting such common symptoms as *headache, pain in the face, sciatica, vertigo, coma, seizures, peripheral neuritis, etc.*—Specific treatment outlined in detail—Acute and chronic organic psychoses analysed in terms of neurophysiology. New material brings you up-to-the-minute on: *the reciprocal relationship between brain function and serum electrolytes—the effects of brain lesions on the electrocardiogram—the use of echoencephalography and brain-scanning in diagnosis.* Any physician desiring latest help in diagnosis and treatment of neurological diseases will find *Clinical Neurology* eminently useful.

By Frank A. Elliott, M.D., F.R.C.P., Chief of Neurology, The Pennsylvania Hospital; Professor of Clinical Neurology, University of Pennsylvania School of Medicine. About 672 pages, 6⅜" x 9¾", with about 179 illustrations. About $12.00. *New—Just Ready!*

W. B. SAUNDERS COMPANY West Washington Square, Phila., Pa. 19105

Please send and bill me:

☐ Moore—*Give and Take*_____About $ 6.00

☐ Nelson—*Pediatrics*_____About $18.00

☐ Easy Pay Plan ($5 per mo.)

☐ Elliott—*Clinical Neurology*_____About $12.00

Name_____

Address_____ SJG 8-64

VOLUME 62 • AUGUST 1964
Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Sam A. Overstreet, M.D.

• ASSOCIATE EDITOR
Walter S. Coe, M.D.

• MANAGING EDITOR
J. P. Sanford

• ASST. MANAGING EDITOR
Ann M. Huntsman

• DEPARTMENTAL EDITORS
Jack L. Chumley, M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscar J. Hayes, Case Discussions
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR
George F. Brockman, M.D., Chairman
Willett H. Rush, M.D.
Blaine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Moore, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1967
Edward C. Groves, M.D.
Carl W. Kumpe, M.D.
Marvin A. Lucas, M.D.
Robert N. McLeod, Jr., M.D.
Henry W. Post, M.D.
Clinton R. Potts, M.D.
Oscar Thompson, M.D.
George I. Uhde, M.D.

Term Expires July 1, 1966
Harold L. Bushey, M.D.
Edward J. Fodell, M.D.
Merle W. Fowler, Jr., M.D.
Joseph L. Goldstein, M.D.
John D. Lovett, M.D.
George F. McAuliffe, M.D.
Ralph G. Thomas, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965
McHenry S. Brewer, M.D.
Lewis Dickinson, M.D.
Zygmunt Gierloch, M.D.
Douglas L. Gillim, M.D.
Arthur H. Keeney, M.D.
James B. Stith, M.D.
Chester B. Theiss, M.D.
Keorns R. Thompson, M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205

Subscription $8.00—single copy .80
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

JOURNAL *of the* KENTUCKY STATE MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

Bilateral Symmetric Recession of the Horizontal Rectus Muscles
Charles A. Perera, M.D. 581

Out-Patient Treatment of Head and Neck Lesions
Andrew M. Moore, M.D. 587

The Pathogenesis and Treatment of Septic Shock
Allan M. Lansing, M.D., Ph.D., F.R.C.S. (C) 590

Paroxysmal Ventricular Fibrillation
William R. Gray, M.D. 596

CASE DISCUSSION

Extensive Carcinoma of the Duodenum Treated by Pancreatico-Duodenectomy and Right Hemicolectomy
J. A. Gallagher, M.D., H. Tesluk, M.D., and F. C. Spencer, M.D. 599

SPECIAL ARTICLE

Doctor Pope and His Building
Ruth Atwood 602

EDITORIALS

For a Better Kentucky 605
The Records Show 606

ORGANIZATION SECTION

Diabetes, Athletic Injury Panels Featured at Annual Meeting 608
Texas Humorist to be Speaker at President's Luncheon 609
KEMPAC Second Seminar Set as Annual Meeting Event 609
Dr. Ward to Head AMA in '65-66; Dr. Welch New President 613
W. K. Young Named New Director of KSMA Field Services 613
Annual Meeting Phone is 584-2201 for Emergency Calls 613
Dr. Archer, Other Presidents Honored at AMA Session 613
Dr. Long Re-Elected to AMA Board of Trustees Post 614
Kentucky Well Represented at AMA Annual Meeting 614
Big Spring Club Will Host 1964 KSMA Golf Tournament 616
AMA House of Delegates takes Stand on Tobacco and Human Rights 618
Large Kentucky Delegation Registers at AMA Annual Meeting 622

REGULAR FEATURES

President's Page 572
Insurance Page 576
Postgraduate Page 620
In The Books 632
Maternal Mortality 636



NTz Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

NTz® Nasal Spray

NTz is more than a simple vasoconstrictor. It contains [N]eo-Synephrine® HCl 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; [T]henfadil® HCl 0.1% for topical antiallergic action; and [Z]ephiran® Cl 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium as chloride, refined), trademarks reg. U. S. Pat. Off. 179648

Winthrop Winthrop Laboratories
New York 18, N.Y.

MESSAGE FROM THE PRESIDENT



KEMPAC is Our Responsibility

THE Republican National Convention was in full swing as this was written. When you read this, the Democratic National Convention will be preparing to get under way. Even if we wanted to ignore "Politics" this summer, news media would prevent us from doing so. Medicine has a growing stake in politics. It is most appropriate for us to become even more knowledgeable and participate more actively in politics.

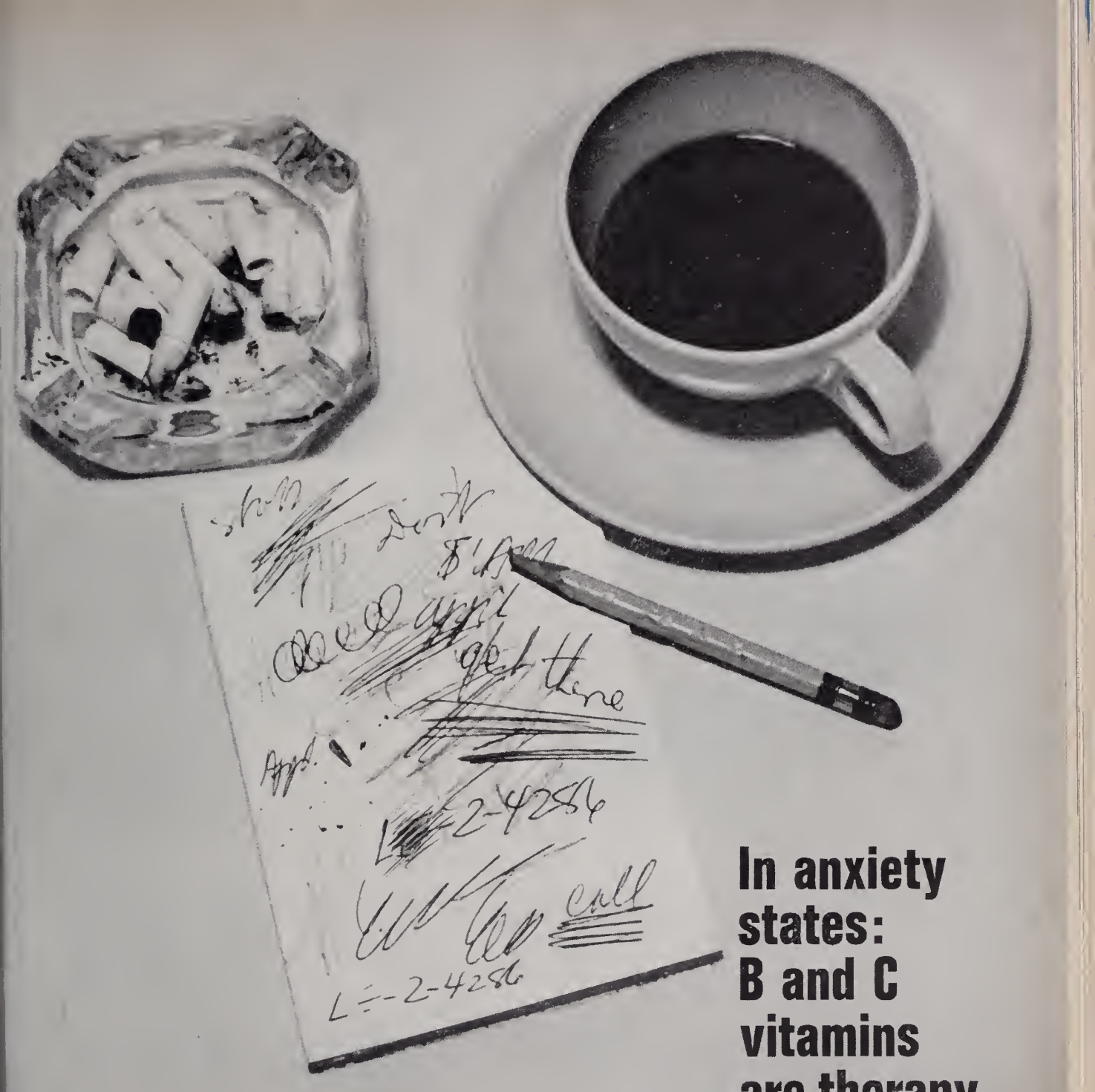
To our friends in labor we are indebted for what was first accomplished by non-profit association participation in political action. It was labor that blazed the trail and established the legal precedents and organizational patterns that enabled its membership to participate in political education and action.

You are aware that medicine, and now business, have realized the necessity of operating in the field of political action. KEMPAC (Kentucky Educational Medical Political Action Committee) led all state "PACs" in percentage of membership enrolled last year. While we are grateful for this, we still have far to go if we are to be truly effective in political actions.

Yes, Presidents are important, but KEMPAC and AMPAC must concentrate on Congressional elections. Here is our greatest opportunity for effectiveness. As Ralph E. Whitehead, M.D., pointed out editorially in the July issue of the KAGP Journal, "The sole purpose of KEMPAC is to help elect officials in government regardless of party who wholeheartedly support the free enterprise system."

What can you and I do in the days that are immediately ahead? As civic-minded physicians we can remit our 1964 dues and the dues of our wives to KEMPAC. We can encourage our colleagues to do the same. Then on the late afternoon and evening of September 28 (the first day of KSMA Annual Meeting) we can attend the Second Annual KEMPAC Seminar at the Kentucky Hotel, when a truly outstanding program of great value to us all will be presented.

George O. Archer M.D.



In anxiety states: B and C vitamins are therapy

Stress formula vitamins are an important supportive measure in maintaining the nutritional status of the emotionally disturbed patient. With STRESSCAPS, B and C vitamins are present in therapeutic amounts to meet increased metabolic demands. Patients with anxiety, and many others undergoing physiologic stress, may benefit from vitamin therapy with STRESSCAPS.

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

0241-4

ARTHRALGEN® helps free



ARTHRALGEN®

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.

Arthralgen, a better-tolerated analgesic formulation of time-tested ingredients, works faster to free the arthritic from his pain without salicylate side effects. Since its analgesic components require no chemical conversion to act in the body, Arthralgen's pain relieving benefits are immediately available to provide a smoother, more rapid obtundation of pain than can be achieved with many true salicylates.

Arthralgen is especially useful for the prompt relief of early morning stiffness and pain with less risk of gastric irritation. And since Arthralgen contains no sodium it is safe for long-term use in arthritics who have other conditions which neces sitate sodium restriction.

ARTHRALGEN®-PR

Each tablet contains:

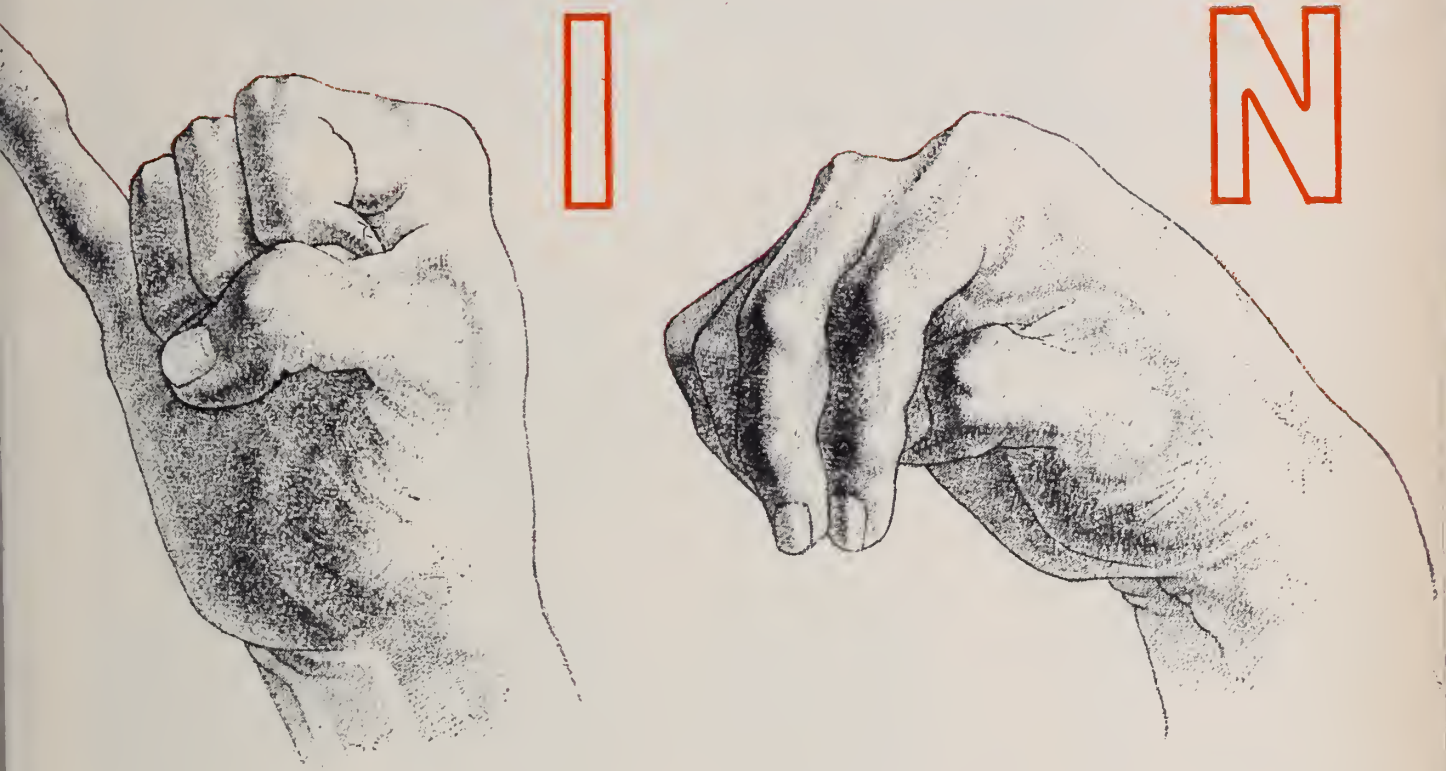
Salicylamide	250 mg
Acetaminophen	250 mg
Ascorbic acid (Vitamin C)	25 mg
Prednisone	1 mg

The basic Arthralgen formulation plus predni sone is indicated for patients who require steroids Prednisone has three advantages over cortisone hydrocortisone, and ACTH. They are: (1) lack o sodium retention, (2) absence of increased potas sium excretion, and (3) the unlikelihood of steroi induced hypertension.*

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated i the management of rheumatoid arthritis, acut

arthritic joints from



uty arthritis, rheumatoid spondylitis, osteoar-
ritis, bursitis, fibrositis, and neuritis. Arthralgen
ay be used for analgesia in colds, flu, and
rious myalgias.

OSAGE: One or two tablets four times a day.
ter remission of symptoms, dosage should be
duced to the minimum maintenance level.

DE EFFECTS: Nausea, GI upset, or mild salicy-
m may rarely occur. Symptoms of hypercorticoid-
m dictate reduction of dosage of Arthralgen-PR.

RECAUTION: Reduction in dosage of Arthral-
n-PR given over a long period should be gradual,
ver abrupt.

ONTRAINDICATIONS: Hypersensitivity to any
gredient.

s with any drug containing prednisone, Arthral-
n-PR is contraindicated, or should be adminis-
tered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

A. H. ROBINS CO., INC.
RICHMOND, VIRGINIA



Major Medical Insurance—And Physicians' Fees

IN order to meet the rising cost of medical and hospital care in the past few years, it has become necessary for the various types of voluntary prepayment plans to develop mechanisms by which adequate coverage could be provided against these higher costs. This, too, without raising the premium rates to levels which these who most need the protection could ill afford.

Among such mechanisms we find the Major Medical programs which are offered by our own Kentucky Blue Shield plan, as well as by many commercial insurance companies.

To make possible this increased protection, and at the same time to protect the pooled funds from which the payments are made against abuse and unnecessary utilization, the principles of "deductibles" and of "co-insurance" have been employed. In this way, the insured becomes a partner in the attempt to avoid unwarranted and excessive claims against the funds, since he must pay a specified amount (such as fifty dollars) from his own pocket before the insurance plan takes over; and he must also pay a certain percent (usually twenty percent) of the remaining amount.

Through these mechanisms the insuring company can now pay to the subscriber amounts greatly in excess of the limits which were necessary under the older types of coverage.

Unfortunately, there is reason to believe that there are a few physicians (*only* a few, we hope) who have adopted the philosophy that because of the additional coverage now available, they may charge those thus covered, fees in excess of those that would normally be submitted to a person of moderate circumstances.

Such a practice must be mentioned only to condemn it.

First, as already mentioned, the patient must pay from his own pocket for the deductible and co-insurance portions of the total cost. In many instances, this could mean that the insured has actually had less protection against the cost of his illness than he might have had from a less adequate type of program (to say nothing of the larger premium which the better program entails).

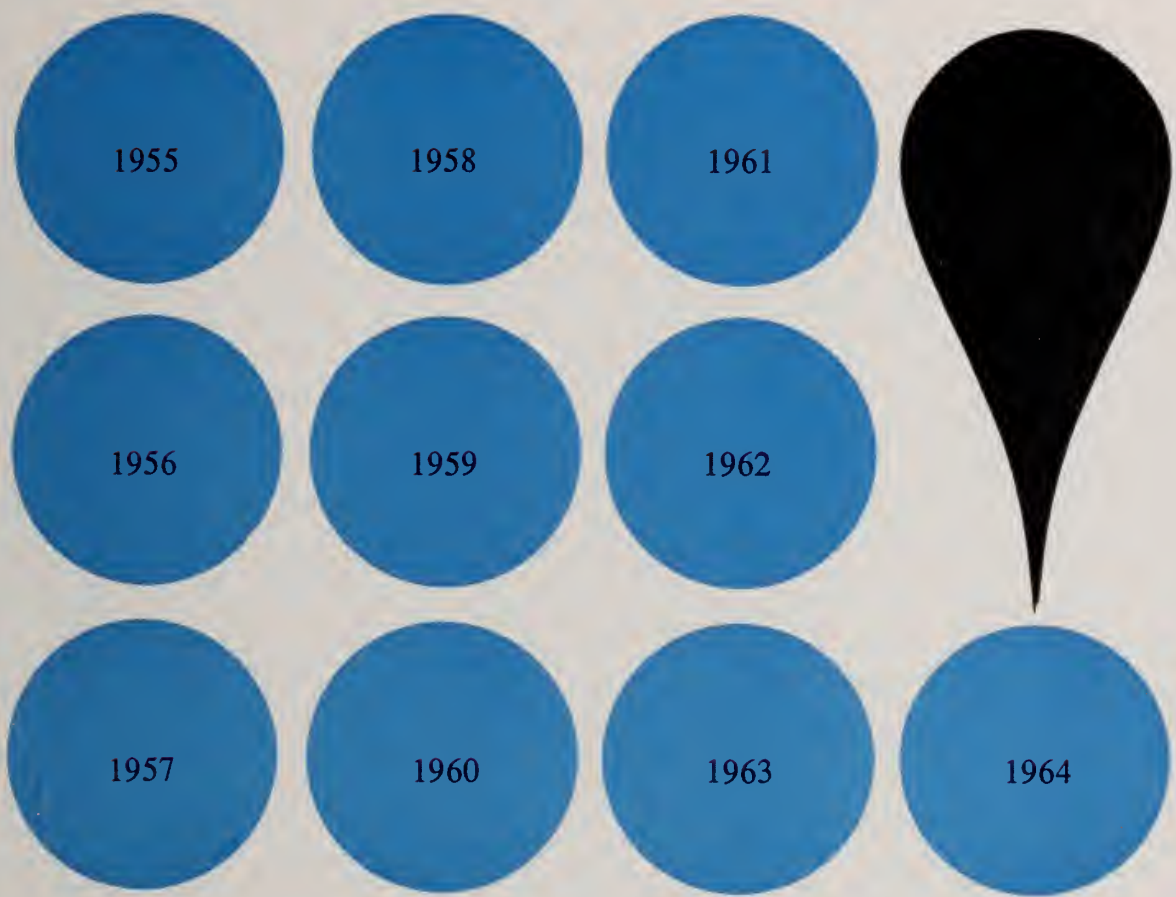
A corollary to this could well be a loss of confidence in the improved program, and a return to the less expensive coverage, or even to abandonment of all prepayment pretection.

Another undesirable result of such practices would be that abuse of the pooled funds (which are derived solely from premium income) would lead to higher premium rates. Thus, all participants in the program would suffer.

We repeat here what we have often said previously;—that loss of confidence in voluntary prepayment could and probably would cause a strong public demand for some type of governmentally controlled health care program.

W. VINSON PIERCE, M.D.

The clear conclusion from 10 years' experience...



belongs in every practice

Miltown®
(meprobamate)

WALLACE LABORATORIES/Cranbury, N. J.

CM-2026

THE DERMATOSES THAT WERE STEROID-UNTREATABLE

Salt and water retention, edema, overstimulation of the appetite, excessive weight gain, mood swings—these were some of the problems that used to confront physicians when they wanted to prescribe steroids for dermatoses. For patients already overweight, or with edema associated with cardiovascular disease, or those who were tense and anxious, steroid treatment could aggravate their problems. But with the advent of ARISTOCORT® Triamcinolone, many of these patients became "steroid-treatable." The reason: Not only did *this* steroid provide gratifying symptomatic relief, but it did so *without* the penalty of overstimulation of the appetite, excessive weight gain, salt and water retention, edema, and undesirable euphoria. And these benefits have been confirmed for other patients with steroid-susceptible disorders, as well as those formerly untreatable.



Side Effects: Since it may, under some circumstances, produce many of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.
Contraindications: While the only absolute contraindications are tuberculosis, herpes simplex and chicken pox, there are some relative contraindications (peptic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.
A single daily dose may provide effective control, is convenient for the patient, and can be employed in both initial and maintenance therapy.

MAXIMUM STEROID BENEFIT—MINIMUM STEROID PENALTY

Aristocort®
Triamcinolone
1 mg., 2 mg., 4 mg. or 16 mg. tablets

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

272-4





thrown for a loss...

Keeping flies out of pharmaceutical production areas is important, yet entrances must accommodate heavy traffic of people and materials. In fact, at Eli Lilly and Company, the entrances to certain production facilities where traffic is heaviest have no screens or doors. ☐ This makes it look easy for flies to get in. But let one try it and he is literally picked up by a fast-moving blast of air and thrown for a loss—back outside. This "curtain of air," moving down and out from the top of the open doorway, bars the entrance and keeps flies out . . . still another step demonstrating the care that goes into the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

401004

The JOURNAL of the
Kentucky State Medical Association

Issued Monthly Under the Direction of the Board of Trustees

VOLUME 62 AUGUST, 1964 No. 8

Bilateral Symmetric Recession of the Horizontal Rectus Muscles†

Charles A. Perera, M.D.*
New York, N. Y.

The results of a standardized bilateral symmetric recession of the medial or lateral rectus muscles are presented in 172 patients with infantile esotropia, convergence excess esotropia and divergence excess exotropia.

RECESSION of a horizontal rectus muscle involves reattachment of the muscle to the sclera at a predetermined position posterior to its original insertion. The new linear attachment should be as broad as the initial one, Tenon's capsule should be disturbed as little as possible, and the tissues should be closed to preserve the normal anatomic arrangements.

The rectus muscles of the eye pass through Tenon's capsule to be attached to the sclera. The muscle sheath merges into Tenon's capsule, which continues forward beneath the conjunctiva to its scleral adhesion near the limbus. The sheaths and Tenon's capsule form an intermuscular membrane between adjoining rectus muscles. Surgical recession of a rectus muscle should permit its tendon and belly to retract beneath the outer muscle sheath and its fused Tenon's capsule. The scleral surface of the sheath must be preserved with the reattached muscle. When the surgeon considers these factors in his operation, there will be little derangement of the check ligaments and the receded muscle will be adherent to the sclera only along the line of its new insertion.

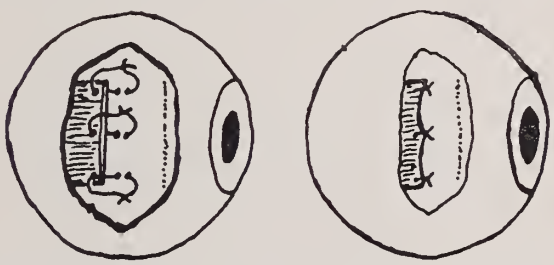


Figure 1. Method for Recession Operation (from Worth's Squint by Chavasse).

Figures 1 and 2 illustrate methods of suturing the muscle posterior to the original insertion from which it has been shaved or separated from the sclera by snips of the scissors. The amount of postplacement can be marked on the sclera by the point of the measuring calipers or by some other method. In this way, the distance of the recession can be measured to within 0.5 mm. The conjunctiva and underlying Tenon's capsule can be sutured together or by separate handling of these layers, as advocated by Swan and Talbot[1].

The standard procedure which I have employed consists in rotation of the globe by traction with forceps to expose the site of operation, a vertical incision with Stevens scissors just anterior to the muscle insertion, and opening Tenon's capsule above the muscle, which is then delivered on a muscle hook. The conjunctiva, underlying Tenon's capsule and muscle sheath are then separated from the muscle by blunt and sharp scissors dissection,

†*Presented at the September 26 meeting of the Kentucky EEN&T Society during the 1963 KSMA Annual Meeting in Lexington.*

**Associate clinical professor of ophthalmology at Columbia University College of Physicians and Surgeons, New York.*

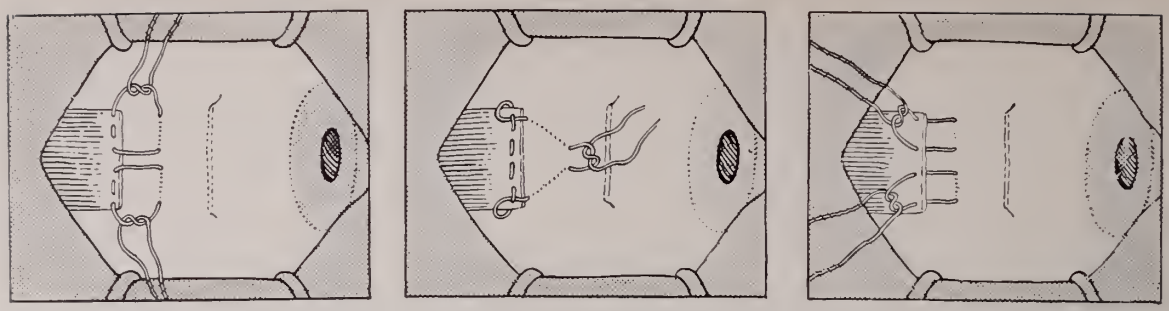


Figure 2. Methods for Recession Operation (from Perera, C.A., New York State Journal of Medicine, Vol. 50, No. 20, Oct. 15, 1950).

and the intermuscular membrane is cut obliquely above and below the muscle for a distance about equal to the proposed recession. The muscle tendon is transfixed with a 4-0 plain gut double-armed suture close to the sclera. The upper and lower ends of the suture are passed through the extremities of the insertions by a double overhand knot which ties off the vessels in this area and maintains the width of the muscle ribbon. The tendon is severed by snipping as close to the sclera as possible, and the muscle allowed to retract. Any other adhesions between muscle and sclera must be cut. The sclera is then marked behind the superior and inferior extremities of the original insertion. With scleral fixation in the region of the stump, the sutures are passed through the marked spots and angled toward each other in the outer layers of the sclera before being brought out. A muscle hook is passed under the muscle to be certain that portions of Tenon's capsule are not caught up in the suture, which is then tightened and tied. The conjunctiva and underlying tissue are brought together by interrupted 5-0 plain gut sutures. An antibiotic ointment is placed in the conjunctival sac. In recent years I have used no dressing.

Recession of both lateral or medial rectus muscles is indicated in selected patients with comitant horizontal strabismus. In esotropia, the medial rectus muscles require relaxing if the deviation is greater for near than for distance. In patients with exotropia associated with divergence excess, the lateral rectus muscles should be retroplaced. In children with congenital or infantile esotropia, often accompanied with apparent weakness of abduction, I have performed a full 4.0 mm. recession of each medial rectus muscle.

This paper does not deal with patients in which the primary procedure involved resections, operations upon the vertical-acting muscles, or combined procedures.

Costenbader and Albert[2] have written an excellent survey of strabismus surgery. I am in general accord with their indications for surgery, treatment of patients and with their conclusions. With the method of recession which I use, I have considered 4.5 mm. as the maximum for the medial rectus, and 6 mm. as the limit for the lateral rectus.

When surgery is needed, it should be done as early as possible. Keith Lyle and Bridgeman[3] emphasize that the aim of surgical treatment is to supplement other therapeutic measures if the deviation persists when the eyes have been made as nearly equal in visual acuity as circumstances permit by correction of ametropia and occlusion. Although not always feasible, it is wise to correct amblyopia, abnormal retinal correspondence and suppression before performing surgery. Urist,[4] in a recent interesting paper, bases his surgical treatment of horizontal strabismus on the concept that the position of the eyes is determined by the existence of a state of balance between convergence and divergence. Preoperative examination of the patient must include measurement of the deviation, with accommodation controlled and ametropia corrected, at 20 feet and at 18 inches. It is important to know if there are changes in the angle of squint in the eight cardinal directions of gaze.

This study deals with 172 consecutive patients treated by bilateral symmetric surgery who have been followed carefully since operation between 1948 and 1961. The recession operations were performed as described above, upon the medial rectus muscles in patients with esotropia, and upon the lateral rectus muscles in those with exotropia.

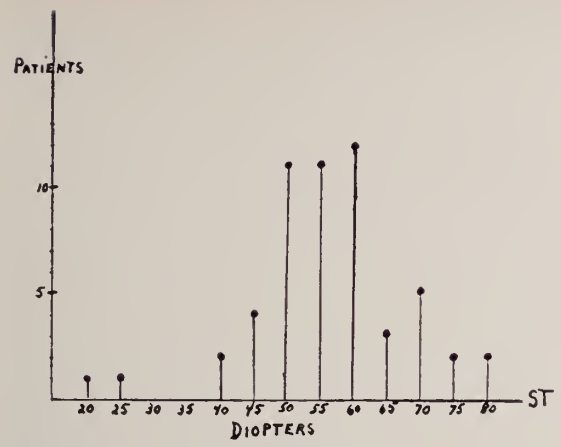


Figure 3. Deviations in Infantile Esotropia.

Congenital or Infantile Esotropia

This group of 54 children (40 males, 14 females), gave a history of crossed eyes since birth or noticed before the age of 4 months. I have followed them for an average of 6.8 years after operation.

The esotropia measured from 20 to 80 prism diopters, averaging 56 (Fig. 3). In fifty patients with deviations from 40 to 80 prism diopters, a 4 mm. recession was done on each eye. In the remaining four children, recessions of 3.5 and 3.0 mm. were performed.

There was some overaction of the inferior oblique muscles in 23 (42%) youngsters. Among these seven required a second operation. Of the remaining 31 children, another nine were undercorrected and one was overcorrected (in a retarded male born prematurely), for ten additional reoperations.

Of the total second operations in 17 (31%) patients, two needed recession of both inferior obliques, six required inferior oblique weakening combined with resection of a lateral rectus (Fig. 4) and lengthening of a medial rectus (Fig. 5), and nine were corrected by surgery upon the horizontal muscles.

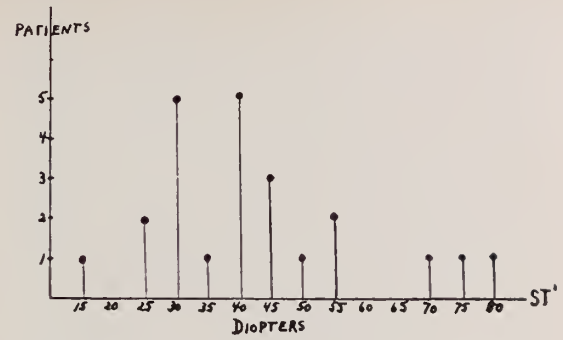


Figure 7. Deviations in Convergence Excess Esotropia.

The effect of a 4 mm. recession on each eye, shown in Fig. 6, reveals that the amount of correction obtained varies and is unpredictable.

All patients were somewhat hyperopic, except for one child who was myopic in each eye (− 5.00 Sphere) and who ended up with a small right esotropia and no fusion.

Among the 18 cases which developed fusion, the average age at operation was 23 months (10 to 42 months). No fusion was obtained in 36 patients, the average age at operation being 28 months (7 to 168 months). Orthoptic exercises, judged worthwhile in four children, resulted in the development of fusion in two. Three patients needed glasses, correcting a hyperopia of 3 to 4 diopters, to maintain fusion.

Esotropia Associated with Convergence Excess

These 23 patients (13 males, 10 females), followed for an average of 7.9 years after operation, had not responded to treatment with full correction of their refractive errors, the use of D.F.P. 0.025% and orthoptic exercises.

The esotropia measured 15 to 80 prism diopters for near vision with full correction of the hyperopia or under the influence of D.F.P., averaging 42 prism diopters (Fig. 7). In 12 patients, a 4.0 mm. recession of each medial rectus muscle was performed to treat the ac-



Figure 4

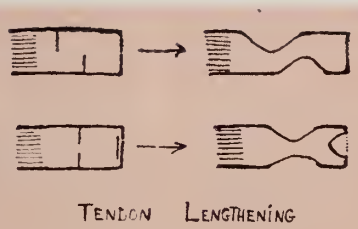


Figure 5

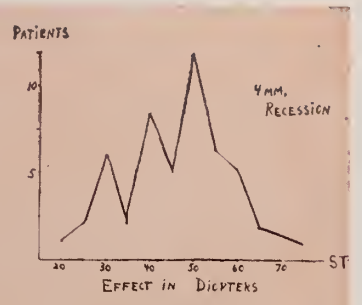


Figure 6

Figure 4. Lancaster Method for Resection Operation.

Figure 5. Two Methods for Lengthening Tendon.

Figure 6. Reduction in Deviation by Bilateral Recession of Medial Rectus.

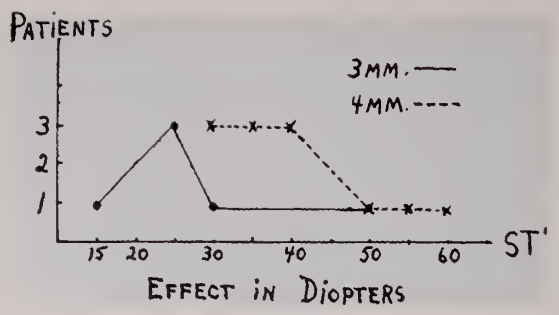


Figure 8. Reduction in Deviation by Bilateral Recession of Medial Rectus.

commodative portion of the squint measuring 25 to 80 prism diopters (25, 30, 40, 40, 40, 40, 50, 50, 55, 70, 70, 80). A 3.5 mm. recession was done in five patients, with esotropia of 45, 45, 40, 35, and 25. In the remaining six patients, a 3 mm. recession was done to treat esotropias of 15, 15, 30, 30, 30, and 55.

From the history, the strabismus began at an average of two years (six months to four years). Operation was undertaken at an average age of five years (22 months to nine years), with an interval of three years (nine months to six and a half years) between onset of squint and surgery.

In this group, a second operation was needed in the patient with the esotropia of 80 prism diopters, four years after the initial procedure. Her squint was noticed at the age of six months, and perhaps she belongs in the infantile esotropia group. This patient now has fairly straight eyes, good vision in each eye, and no fusion, following a resection of the right lateral rectus and a lengthening of the right medial rectus muscle.

One third of the patients had some over-action of the inferior oblique muscles, but none of these required a second operation.

Figure 8 shows the corrective effects of 3 and 4 mm. recessions.

All of the patients were hyperopic (1.50 to 4.00 Sphere). Of these, two became emmetropic, and one slightly myopic.

Among the 18 cases which developed fusion, the average age at the time of operation was five and a fourth years (two and a fourth to nine years). One child in this group had a postoperative exophoria which gradually disappeared after a year. No fusion was found in five patients, their average age at operation being three years and nine months (one and a half to six years). Glasses were required in six children to maintain fusion.

Preceding operation, orthoptic exercises were employed in five patients and D.F.P. in four.

Exotropia Associated with Divergence Excess

These 95 patients (58 females, 37 males) had excessive exophoria, greater for distance, occasional or constant exotropia on distant gaze, easily disturbed binocular fixation at far gaze, suppression of vision in the deviating eye, and good convergence. At times, one eye drifted out when daydreaming or was closed in sunlight. This group has been followed for an average of 6.7 years after operation.

Onset of the divergence was recorded at an average age of two and three quarters years (birth to eleven years). Twelve of the children had a divergent squint before the age of six months; of these two failed to obtain fusion, and another required a second operation to develop fusion.

The exotropia averaged 33 prism diopters (15 to 60) for distance with correcting lenses (Fig. 9). The interval between the onset and operation was 3.9 years (six months to 16 years). Six patients were operated upon ten or more years after the deviation was noticed.

A second operation was needed in nine patients. Of these, one underwent recession of a lateral rectus, seven had resection of the medial rectus and lengthening of the lateral rectus of one eye, and the last one, who had the "A-phenomenon," was treated by tenotomy of both superior obliques accompanied by resection of the medial rectus and lengthening of the lateral rectus of one eye. Of these nine reoperated patients, five were not able to fuse.

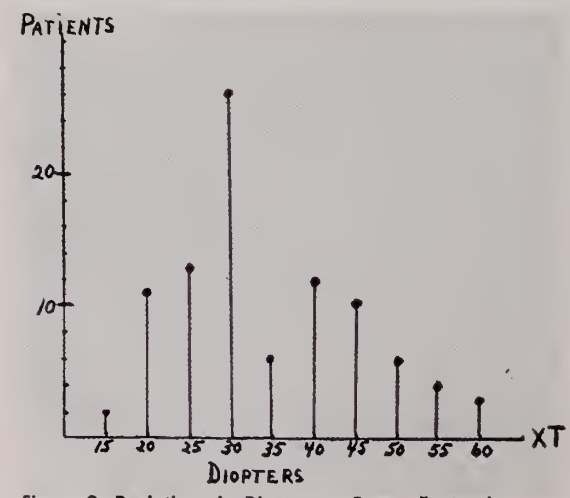


Figure 9. Deviations in Divergence Excess Exotropia.

My records show, in the following table, the correlation between amount of recession and the deviation to be corrected:

Number of Patients	Amount of Recession (Bilateral)	Average Exotropia
9 (1 reop.)	6 mm.	50 prism diopters
5	5.5	40
55 (5 reop.)	5	38
8 (1 reop.)	4.5	28
18 (2 reop.)	4	27

Of the total 95 patients, fusion could not be attained in 11 individuals.

The refractive errors of this group included myopia at the onset in 12, the development of myopia in another 14, and anisometropia in 6 (of these five had good fusion).

In four patients, the final outcome was an esophoria of 3 to 5 prism diopters.

The corrective effects of 4, 5, and 6 mm. recessions are shown in Figure 10.

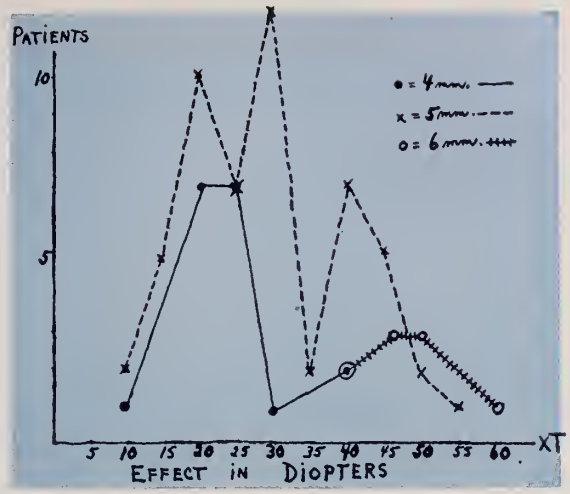


Figure 10. Reduction in Deviation by Bilateral Recession of Lateral Rectus.

Discussion

The resulting correction obtained by a given amount of bilateral symmetric recession of the horizontal rectus muscles is not predictable, even though the operative procedure is standardized. It is possible to state only that a larger recession on the average produces more correction.

In the infantile esotropia group, the need for a second operation was not related to the amount of the initial deviation nor to the apparent weakness of abduction. Following one or two operations, all of these patients manifested good ability to abduct each eye, but I cannot be certain that an associated lateral rectus weakness was not present. Uncorrected high grade infantile esotropia may develop permanent contracture of the medial rectus muscles and give rise to the clinical picture of so-called strabismus fixus.

In the convergence excess group, surgical correction should be aimed at the non-accommodative portion of the total deviation. It seems advisable to have the patients wear the full correction of their refractive error before determining what part of the squint is accommodative.

I have not included in this paper a series of young adults with an exophoria large enough to fail the ocular requirements for becoming Flying Cadets. Under the auspices of the American Flying Services Foundation, I examined a number of young men who desired to become airplane pilots at the beginning of the last World War. In 36 candidates whose sole defect was excessive exophoria, a 2 to 4 mm. recession of both lateral rectus muscles enabled 35 to pass the ocular requirements for pilots. One patient still had a disqualifying exophoria and became a navigator.

In all patients when subsequent surgery is needed, the procedure should be based on the same diagnostic principles as the original operation. In the series reported here, there was no indication for a third operation.

Of the 172 patients, only one child with infantile esotropia was overcorrected. He was born prematurely with an alternating esotropia of 50 to 60 prism diopters. Following a 4 mm. recession of each medial rectus muscle, he gradually developed a right exotropia which increased from 15 to 30 prism diopters, beginning two years after operation. A second procedure, performed eight years after the initial one, gave a good cosmetic result.

Of the 369 eyes in which a horizontal rectus muscle was treated surgically by one or two operations, a postoperative epithelial inclusion cyst appeared in three instances, an incidence of 0.8%.

Summary

The technic of recession of a horizontal rectus muscle is presented, based on the anatomy of the tissues and the least possible disturbance of the normal anatomic arrangements.

Methods of recession are suggested for accurate reattachment of the muscle at a predetermined position posterior to the original insertion. The author describes his procedure.

General principles of the surgical treatment of strabismus are outlined.

Bilateral symmetric recession of the medial or lateral rectus muscles was performed on 172 patients between 1948 and 1961, with continuous follow-up to the present time.

The patients consisted of 54 with congenital or infantile esotropia, 23 with convergence excess esotropia, and 95 with divergence excess exotropia.

Preoperative findings and postoperative results are given. Fusion for near and distance was obtained in 18 (33%) of the first group, 18 (78%) of the second, and 84 (88%) of the last.

A second operation was needed in 17 (31%), one (4%), and 9 (9%) of the three respective groups. A third operation was not necessary in this series.

The correction resulting from a given amount of bilateral recession of a horizontal muscle is not predictable. On the average a larger recession produces more correction of the initial deviation.

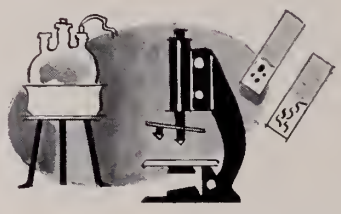
References

1. Swan, K. C. and Talbot, T. E. *Recession under Tenon's capsule.* A.M.A.Arch. Ophth. 51: 32-41, 1954.

2. Costenbader, Frank D. and Albert, Dan G. International Ophthalmology Clinics. Vol. 2, No. 4. December 1962 (Little, Brown and Company, Boston).

3. Lyle, T. Keith and Bridgeman, G.J.O. *Worth and Chavasse's Squint.* Ninth Edition. 1959. (Bailliere, Tindall and Cox, London).

4. Urist, Martin J. *Surgery in Horizontal Strabismus.* Am. J. Ophth. 55:1 pp. 62-80, Jan. 1963.



Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

Out-Patient Treatment of Head and Neck Lesions

ANDREW M. MOORE, M.D.*
Lexington, Ky.

Out-patient treatment of head and neck lesions can more often than not be accomplished if a careful analysis of the situation and its requirements are made. To assure success, the patient and his tissues must be handled with meticulous care and consideration.

WHILE a face may not be a fortune, even the most phlegmatic citizen has an increased awareness of those features which are most constantly regarded by his fellow man. This consciousness brings patients to the doctor for advice regarding lesions which, if located elsewhere on the body, might be completely overlooked.

Every day the practitioner is asked about a wide variety of problems, such as small benign papillomas and moles, sebaceous cysts and scars. Often the lesion is large or malignant. These confrontations range from those informal encounters in the corridors of hospitals or at a dinner party where one is asked to render an opinion regarding a small bump or lump, to formal consultations sought at the office or the acute situation seen in the emergency room.

In- or Out-patient?

In many instances these may be handled on an out-patient basis. However, consideration must be given to the magnitude of the problem and the suitability of the patient for such care. Lesions of that size and location which preclude removal with ease and celerity should be treated on an in-patient basis under general anesthesia. It is unwise to subject a patient, even with supplementary sedation, to any procedure lasting over one hour. In fact, it is probably more discreet to limit one's self to such operations as can be readily accomplished within thirty or forty minutes. When patients are subjected to surgery under local anesthesia for a longer period of time, they become increasingly restive, if not apprehensive. The operating table, the bright lights, and the glittering array of instruments are not conducive to peace of mind even in the most stoic individual.

Many persons are unable to cooperate because of age, mental or physical incapacity. To attempt to carry out an elective procedure, however small, on a young child is most unsatisfactory. The child is apt to be terrified; if so, the surgeon will be frustrated and the results will be poor. (It is recognized that the small child, even the infant with a small laceration, can be cared for as an out-patient. In acute injuries the hazard of anesthesia created by a full stomach may outweigh the risks of a not entirely satisfatory result of a procedure undertaken under local anesthesia.) Those whose disabilities are such that in spite of the best intentions they are unable to lie quietly while they are being cared for, should be treated otherwise.

In making these somewhat arbitrary decisions as to whether a patient should be cared for as an in-patient or an out-patient, the problems must be discussed in detail with those concerned. A clear understanding must be reached between the patient or family and the physician as to the possibilities and probabilities. It should be recognized that an incision or laceration invariably leaves a scar. Time taken in this fashion allays fear and avoids misunderstanding.

Having made the decision that the patient and the lesion will permit care as an out-patient, consideration should be given as to how this best can be accomplished.

†*Presented before the Kentucky Academy of General Practice during the 1963 KSMA Annual Meeting in Lexington, Ky., September 25, 1963.*

**Assistant professor of clinical surgery at the University of Kentucky College of Medicine, Lexington, Ky. President of the Fayette County Medical Society, 1964.*

Sedation and Anesthesia

Will sedation be necessary or desirable? Very often in dealing with small acute injuries in the young fear may be controlled by use of appropriate drugs. Mixtures of Demerol® and Phenergan® using 1 milligram of each per pound (Largon® 0.3 milligram may be substituted for the latter) will often produce the desired state of tranquillity. Demerol, Phenergan and Sparine®, using 1 milligram, 1.5 milligram and 0.5 milligram respectively, are also excellent. The use of barbiturates is somewhat uncertain and frequently considerable excitement may occur.

The head, face and neck lend themselves well to regional blocks with local anesthesia. However, field blocks or local infiltration are quite satisfactory in many instances. Any past history of untoward or allergic reaction to previous similar injections must be ascertained. If a positive history is obtained, certainly no attempts should be undertaken to use local agents. General anesthesia on an out-patient basis is usually not desirable or safe.

Consideration must be given to the estimated amount of drug which will be required and an appropriate dilution selected so that the patient is not given large quantities. In general, one percent or less concentrations of the local anesthetics available today are quite sufficient. The amount used should not, except in rare instances, exceed 30 cubic centimeters.

Since there is a tendency, even on the smallest lesion, to use a "syringe full", it is well to select the 2 to 3 cubic centimeters type. A small needle, 25 to 27 gauge, is used for the injection. It is inserted with the bevel down, at which time a wheal is created in the skin, numbing the immediate area. As few puncture wounds as possible should be made, not only for the patient's comfort but also to reduce the trauma to the area. In acute injuries injection into the recently created wound edge, if gently done, produces little or no protest from the patient.

Planning Technique

In planning a procedure thought must be given to the natural creases or folds of the skin. About the face and neck these do not necessarily correspond to the lines of Langer. They do run in a direction generally perpendicular to the underlying musculature. These lines are not constant and vary somewhat from individual to individual. They are readily discernible in the older patients, less so in the middle-aged, and often difficult to ascertain in the very young. However, by pushing and pulling on the skin one can create folds which will delineate the natural creases. Incisions placed parallel to or within them generally produce a less conspicuous scar.

Adjacent features should not be distorted, either by the placement of the incision or the repair of the wound. It may be desirable in injuries to change the general line of a laceration by interpolating small flaps and creating a "Z". In certain cases the use of a small full thickness graft or the rotation of a local flap may be required to close a defect in such a fashion as to minimize the residual deformity. It is poor practice to permit any wound to heal by secondary intention except in the most rare instances.

The tissues should be handled with the utmost gentleness. Although the blood supply is superb in the area being discussed and permits repair which elsewhere might not be possible, the finest results are obtained only by meticulous technique. Skinhooks and tiny forceps should gently grasp the tissue; incision should be made perpendicular to the skin; hemostasis should be obtained by clamping only the bleeding vessel and tying it with the finest of ligatures. When ellipses of skin are excised the wound edges should be gently undermined with a sharp No. 11 blade, tension being kept on the skin edges by the placement of skinhooks at either end of the ellipse. This undermining can be supplemented by sharp dissection with scissors. When adequate relaxation is accomplished and hemostasis obtained, wound edges are approximated with buried sutures of either very fine catgut or white silk.

Skin closure can be obtained by simple suture, utilizing 6-0 silk; these are placed quite close and perpendicular to the wound edge, extending through the derma and tied in such a fashion as to oppose the tissue but not constrict it. The use of monafilament nylon subcuticular suture in linear wounds create excellent closure which may be supplemented by a few 6-0 silks or "Steri-Strips". Dead space should not be permitted within the wound and devitalized tissue should not be left behind.

Dressing and After-care

No procedure is complete until an adequate dressing has been applied. Fine mesh gauze should be placed adjacent to the wound. This diminishes adherence when removed, yet permits adequate drainage. Water soluble emollients may be used on this gauze to lessen sticking. Fine mesh vaseline gauze is also quite suitable. These are overlayed with either mechanics waste or "fluffed up" gauze and the whole held in place by adequate strapping, using either an elastic or simple adhesive. In some instances it may be desirable or necessary to use a wrap-around dressing. It should be firmly and snugly applied, avoiding folds or turns which prevent even distribution of pressure and support.

The patient should not be dismissed until informed of what to expect as to pain and discomfort. If there is any uncertainty about the patient's well being he should be observed as long as needed before being sent home. Adequate medication for pain should be prescribed. It is rarely necessary to use anything more than half a grain of codeine with ten grains of aspirin every three or four hours. Barbiturates may be needed for sleep. A date to return for inspection of the wound is also given. In general, sutures should be removed on the third to fourth day. Instructions are given to contact the physician if there is any concern.

The success of such procedures as outlined above depends on the skill and technical ability of the individual carrying it out, but also to a great extent on the care and consideration that is given to the patient as an individual. Sympathy and understanding not only enhance the success of the procedure but will lead to a truly satisfied patient.

Summary

In summary, the great majority of lesions of the head, face and neck lend themselves to out-patient care and treatment. In order that success may be achieved, thought must be given to the suitability of the lesion and the patient for such a procedure; the selection of an appropriate method and anesthetic agent; and the practice of the most meticulous technique. Understanding by the doctor as well as the patient of what is to be done, how it is to be done, and what can be accomplished, are prerequisites for a happy ending.

Avoid Being Inconvenienced

Make Your Hotel Reservations Now

for the

KSMA Annual Meeting

Sept. 29 - Oct. 1 *Louisville, Ky.*

The Pathogenesis and Treatment of Septic Shock†

Allan M. Lansing, M.D., Ph.D., F.R.C.S. (C)*

Louisville, Ky.

A shaking chill heralds the onset of septic shock, the hypotension being caused by peripheral pooling of blood. Reticuloendothelial failure, histamine release, and toxic hypersensitivity may be pathogenic factors. The keys to successful therapy are time, antibiotics, vasopressors, cortisone, and correction of acidosis.

With the advent of an aging population and the development of more extensive surgical procedures, an increasing incidence of septic shock has been noted. The extremely high mortality rate of this condition has stimulated intense interest in its pathogenesis and treatment. The purpose of this paper is to discuss current concepts of etiology, pathogenesis, and treatment.

Definitions

A definition of septic shock is the first essential for an accurate consideration of the diseased state and for analysis of the results of therapy. Although the most obvious definition would be hypotension associated with bacteremia, not every case of hypotension qualifies as a state of shock, which implies that peripheral blood flow is deficient. One of the easiest vascular beds to observe is that of the kidney: when renal blood flow is decreased, oliguria results. Therefore, septic shock is a state of hypotension caused by bacteremia and accompanied by oliguria, signifying decreased peripheral blood flow.

The clinical situations that commonly lead to septic shock are genitourinary tract infections and surgery; gynecological infections and manipulation; many types of gastrointestinal operations, infections and perforations; contaminated blood transfusions; and specific infections such as cholera and dysentery. Septic shock also occurs frequently in patients with decreased resistance, such as those who have wide-spread carcinomas or lymphomas, especially when radiotherapy, steroids, or chemotherapy have been employed in their treatment.

The responsible bacteria are gram-negative in two-thirds of the cases, the commonest organisms being E. coli, proteus, pseudomonas, and bacteroides. One-third of the time gram-positive organisms such as staphylococci, streptococci, and clostridia are involved.

The specific toxic factor in gram-negative organisms is an endotoxin, while gram-positive organisms produce an exotoxin. In the case of E. coli the endotoxin is a phospholipid-polysaccharide-protein complex, the phospholipid being responsible for its toxicity and the polysaccharide for specific antigenicity. The recent availability of pure endotoxin has given a great impetus to experimental investigation of septic shock.

The mortality rate in septic shock is high. In most reports of septic shock due to gram-negative organisms, 50 to 70 per cent of the patients have succumbed. However, not all patients who develop bacteremia progress to a state of shock. If 100 patients have bacteremia, about 20 will have no hypotension, 60 will have hypotension but no oliguria, and only 20 will have the complete syndrome of septicemia with hypotension and oliguria. It is in this latter group that the high mortality rate occurs, and the key to successful therapy is vigorous treatment to prevent the development of this state.

The clinical picture of septic shock is quite characteristic. There is, first of all, a predisposing factor, such as those previously mentioned.

†*Presented at the Annual Meeting of the Kentucky State Medical Association at Lexington, Ky., September 25, 1963.*

**Markle Scholar in Medical Science. Associate professor of surgery, University of Louisville School of Medicine, Louisville, Ky.*

The warning signal of impending disaster is a chill with rigors. This point cannot be emphasized too strongly. The average time between the first chill and the development of shock is only 13 hours, but it may be very much less than this.[3] When a shaking chill has occurred, shock may be on the way, so treatment must be instituted immediately.

Other clinical features include generalized malaise, aches and pains in various muscles, a rapid rise in temperature to 103-106°, and the early development of intense leucocytosis, exceeding 15,000. There are two clinical types of septic hypotension: the so-called "warm hypotension", in which the patient is alert, has a warm dry skin, and has peripheral vasodilatation and increased cardiac output along with a good urinary output despite the low blood pressure; and the "cold hypotension", in which the patient is cold and sweating, and has depressed cerebral function, collapsed veins, and a markedly diminished urinary output. Warm hypotension is a favorable state that responds readily to treatment, but inadequate therapy may allow its progression to the much more lethal condition of cold hypotension.

From this description of the clinical picture, blood pressure and urinary output are selected as guides to therapy. Even if the blood pressure is normal, a low urinary output signifies the need for even more vigorous efforts. Finally, emphasis must be laid once more upon the significance of a shaking chill as the first alarm signal of the possible future onset of shock and of the need for intensive treatment.

Pathogenesis

Normal blood pressure depends on maintenance of an adequate cardiac output and total peripheral resistance. The major factors contributing to cardiac output include venous return, heart rate, and force of cardiac contraction. The total peripheral resistance is regulated by a balance between central control through the sympathetic nerves and local factors in the tissues. Alterations in these factors in septic shock will be summarized briefly.

In animal experiments, one of the earliest and most dramatic changes associated with the administration of endotoxin is a sudden drop in venous return. While venous return is affected by the mechanics of respiration, the pumping action of muscles, and the forward force transmitted from the heart, the major factors that may be altered in shock are blood volume and venous tone. With the exception of those conditions in which severe fluid and electrolyte loss occur, such as severe diarrhea, the blood volume in clinical cases of septic shock has been found to be normal. Despite this fact, it must be noted that even a mild degree of hypovolemia makes the resistance of animals to endotoxin much lower. Later, as well, in the irreversible phase of septic shock, some escape of plasma from the capillaries occurs, with a resultant rise in hematocrit and drop in circulating blood volume. However, in the ordinary case of septic shock there is little alteration in the blood volume.

The changes in venous tone are not clearly defined. When the clinical picture of cold hypotension appears, the peripheral veins are extremely small and hard to puncture. This does not necessarily indicate primary venous spasm, however, but rather first a failure of venous return with secondary collapse or compensatory vasoconstriction of the venous system.

As in any form of hypotension, the expected increase in heart rate occurs, so there is no evidence of deficiency of cardiac function in this area. This tachycardia is effected by nervous control from the central nervous system and by local factors in the heart. The changes in the sympathetic and vagal tone to the heart are brought about reflexly by stimulation of the baroreceptors and chemoreceptors, while the peripheral stimuli to cardiac acceleration include the rise in blood temperature and the action of adrenaline and noradrenaline produced locally and released from the adrenal medulla.

The question of the importance of failure of myocardial contraction in all forms of shock has been debated. The factors involved in the force of contraction include the initial length of the muscle fibre (Starling's law), the duration of diastole, and the nutrition of the myocardium. There is certainly evidence against the importance of myocardial failure in septic shock, at least in its earlier phases. In animals to which endotoxin had been administered, maintenance of a constant venous return through a reservoir resulted in a normal cardiac output and blood pressure.[7] If the venous return was not maintained artificially, cardiac output and blood pressure fell rapidly. In clinical septic shock, cardiac output has usually been found

to be normal, and if it is low, has been associated with a low right atrial pressure, that is, failure of venous return rather than of the myocardium. In the irreversible phase of shock, however, an increased atrial pressure does occur so cardiac failure is a factor at this stage.[1]

Several factors in the pathological physiology of septic shock enhance the possibility of myocardial failure. The low aortic blood pressure results in diminished coronary flow and this factor alone tends to impair myocardial function. Also, inadequate tissue perfusion, both in the myocardium and in the periphery, deprives the tissues of an adequate supply of oxygen, the carbon dioxide content of the tissues rises, and acidosis develops. The state of acidosis weakens the force of myocardial contraction and also makes the myocardium less responsive to the inotropic action of adrenaline and noradrenaline. A rising serum potassium may also result in weaker cardiac contraction. The tachycardia associated with fever shortens the diastolic filling period, and, if marked, may itself reduce cardiac output. Finally, a direct depressant action of endotoxin on the myocardium must be considered although this has not yet been demonstrated.

Total peripheral resistance depends on the viscosity of the blood, the velocity of the blood flow and the calibre of the vessels. The first two factors are not appreciably altered, at least not early in the development of septic shock. The major factor in peripheral resistance is the calibre of the peripheral arterioles. Compensatory vasoconstriction occurs in hypovolemic hypotension, but contrary to popular supposition, in shock states associated with a normal blood volume the peripheral resistance is not greatly increased. In septic shock, both in humans and in animals, the total peripheral resistance is normal at an early stage, and later falls markedly. If at this period the cardiac output is increased, the clinical picture of warm hypotension results, whereas failure of cardiac output leads to the syndrome of cold hypotension.

Pooling

If there is no evidence of myocardial failure, if the blood volume is not diminished, and if the peripheral resistance is normal, the immediate factor in the hypotension and shock caused by bacteremia must be pooling or sludging of blood in the capillaries. It is, in fact, this factor that accounts for the rapid early decline in venous return. In the dog, marked congestion in the portal system occurs with hemorrhage into the bowel wall and lumen. This is not seen to such a severe degree in humans or other animals, but a more widespread pooling of blood takes place. This, then, is the feature peculiar to the early state of septic shock. Blood is pooled in the periphery, venous return fails, and later the peripheral resistance falls.

A great deal of attention has been devoted to the mechanism whereby bacterial toxins effect these cardiovascular changes. One cannot discuss the role of bacteria in shock without paying credit to Doctor Fine, long-time champion of the bacterial theory.[5] He first noted that the administration of broad-spectrum antibiotics to animals before an experimental shock procedure markedly improved the survival rate. Because bacteria could not be found in the blood or tissues, he reasoned that a toxin was being absorbed from the gastrointestinal tract of the animal. Blood from animals dying of irreversible shock did not produce shock in normal animals, but proved fatal when administered to animals in which resistance was lowered by a sublethal shock procedure. Thus the combination of an absorbed toxin along with lowered resistance appeared to be the prerequisites for the state of shock. About this time endotoxin itself became available, and its inactivation by the reticuloendothelial system was demonstrated. Eighty percent of a dose of endotoxin injected into the splenic artery was removed and inactivated by the normal spleen. However, the spleen of a shocked animal or the spleen of an animal that had previously received Thorotrast failed to remove more than 20 percent of the endotoxin, and also failed to inactivate the extracted endotoxin. It would thus appear that failure of the reticuloendothelial system is a critical factor in shock.

Unfortunately, other investigators have not been able to confirm these experiments.[5] Antibiotics have not been uniformly successful in the pretreatment of shock, and the blood from animals dying of shock has not always been found to be lethal to other animals subjected to moderate trauma. Even more difficult to explain is the fact that germ-free animals die in shock exactly the same as their counterparts whose intestinal tracts are teeming with bacteria.

Recently another hypothesis regarding the

mechanism of action of endotoxin has been postulated by Schayer.[5] The local effect of endotoxin in the tissues is a steadily rising concentration of histamine, produced by the reticuloendothelial cells, while its general effect is a massive release of adrenaline and noradrenaline from the adrenal medulla. Early in shock the high concentration of circulating adrenaline and noradrenaline gives rise to vasoconstriction, but later, gradual exhaustion of the adrenal medulla results in a fall in this concentration. At the same time the steadily increasing local concentration of histamine leads to vasodilatation, a decline in peripheral resistance, and sludging of blood.

Acceptance of Schayer's hypothesis would make the use of adrenergic blocking agents contraindicated in established septic shock because the peripheral resistance is low rather than increased. It would also strengthen the position of those who support the use of vasopressor agents in septic shock to restore the balance between the steadily increasing vasodilatation caused by histamine and the steadily diminishing vasoconstriction produced by the catecholamines. There are other points in favor of the vasopressor drugs. By maintenance of aortic blood pressure, these agents maintain coronary flow and cerebral flow, and by their direct action on the myocardium, increase cardiac output.[2] At least in clinical experience the mortality rate in septic shock is lower when vasopressors are used, although it must be admitted that control of clinical studies is very difficult to achieve.[3]

Another important hypothesis to explain the mechanism of endotoxin action is that of an allergic or toxic hypersensitivity to this compound.[4] In rabbits the administration of a sublethal dose of endotoxin 24 hours after an initial sublethal injection gives rise to widespread necrosis of many organs, particularly the liver and the kidney, in which acute tubular necrosis occurs. This is the Schwartzman reaction. In pregnant rabbits the first dose of endotoxin gives rise to this reaction, and this observation has been used to explain the frequency of septic shock in pregnant women. The possibility that such a state of hypersensitivity occurs is the major reason for the administration of cortisone in very large doses to patients in a septic shock. Cortisone is employed to block an allergic response, not as a replacement for the steroid output of the adrenal cortex.

Adrenal Cortical Failure

The role of adrenal cortical failure in shock has been widely discussed. It is true that patients with Addison's disease or a surgical adrenalectomy are very prone to develop a shock-like state after minor trauma, and the adrenal glands of patients and animals dying of shock do show areas of hemorrhage and infarction. However, certain pieces of experimental and clinical evidence suggest that adrenal insufficiency does not truly exist in shock. The cortisone concentration in the blood is rarely diminished, and is usually much above normal values. Administration of ACTH produces a further rise in the level of cortisone, and injected cortisone disappears much more slowly than normal because of diminished hepatic metabolism. The hemorrhage and other changes in the adrenal glands can be reproduced by the injection of large doses of ACTH. Finally, the fear has been expressed that the individual's resistance to bacterial invasion will be further lowered by cortisone therapy.

In spite of these valid criticisms of the importance of the adrenal cortical failure in shock, there are other aspects to be considered. In the clinical situation, progressive failure of response to vasopressors may be reversed by intravenous cortisone. Also, it is a clinical impression, but only an impression, that the survival rate of the patients in septic shock is increased by the administration of cortisone. Certainly, if an allergic or hypersensitivity factor exists in septic shock, a large dose of cortisone may oppose this action as well as the effect of histamine on the peripheral vessels. Finally, the report of Spink and Vick is of considerable significance.[6] After a lethal dose of endotoxin was administered to dogs, the 24-hour survival rate was as follows: controls 0/12; intravenous plasma 0/10; intravenous hydrocortisone 0/10; and vasopressor 0/10. The average survival time was only 11-15 hours. However, a final group of ten animals that received intravenous hydrocortisone in large doses along with the vasopressor to maintain the blood pressure at 90-100 mm. Hg had a permanent survival rate of 60 per cent.

In summary, although there is no evidence for failure of adrenal cortical function in shock, there is a possibility that septic shock involves

a hypersensitivity reaction and that pharmacological doses of cortisone may be beneficial in blocking either this reaction or the peripheral action of histamine on blood vessels. The concensus appears to be that cortisone does no harm, and may do some good.

The biochemical changes in shock are secondary to the physiolgoical alterations and can be passed over with one exception. The development of metabolic acidosis, caused by the inadequate peripheral circulation in septic shock, is highly significant because of its secondary effects: myocardial contractility and response to catecholamines are depressed and the reactivity of the peripheral vessels to circulating and locally-released catecholamines is lessened. Thus acidosis leads both to myocardial failure and to a peripheral vascular collapse. Here, then, is the reason for correction of acidosis in the treatment of septic shock.

Treatment

With this knowledge of the pathogenesis of septic shock, the important and logical measures to be taken in its treatment become self-evident. In order to select the policy that is most appropriate and most likely to result in survival of the patient, one has only to put into practice the lessons learned in the animal laboratory and clinical situation.

The most precious commodity in the treatment of septic shock is time. Time is indeed golden. All the experimental evidence indicates that pretreatment with many agents, for example antibiotics, cortisone, blocking agents, and hypothermia, may result in an improved survival rate. Even treatment very early in the shock state is of some benefit. A little later, however, no therapy is of any avail. A few minutes or a few hours may be vitally important, for once the chance is missed the mortality rate soars. It is probably better to overtreat many patients in order to preclude the onset of irreversible shock in a few.

When should treatment be instituted, and in what cases? Will all cases of possible bacteremia be treated on suspicion? The cardinal indication for therapy must be emphasized once again; it is the *onset of a shaking chill.* Such a warning must be the signal for immediate, vigorous, and intensive therapy.

The first step is to start an intravenous infusion and obtain a sample for a blood culture. If a culture can be obtained from some other site as well, such as a vaginal discharge or a sample of urine, this should be done simultaneously.

Immediately after the culture has been obtained, massive intravenous antibiotic therapy is started. Intramuscular and oral antibiotics are not appropriate because their absorption is slow and unreliable in the shocked patient. It is reasonable to combine a bacteriostatic antibiotic such as chloramphenicol or tetracycline (0.5-1.0 gm. every 6 hours) with a bactericidal antibiotic such as erythromycin or penicillin. The dose of penicillin should be at least one or two million units every four hours. This antibiotic dosage is continued until the results of the blood culture are known or until it is evident that no response to therapy is occurring. Drugs that have nephrotoxic effects are avoided in shock if at all possible.

If the patient's blood pressure is more than 20 mm. Hg below his normal value, or if his urinary output is low, an intravenous vasopressor agent is started. The purpose is to increase the total peripheral resistance, to maintain the venous return and aortic blood pressure, and to increase the force of cardiac contraction.[2] The vasopressors that have a particularly potent myocardial action are noradrenaline and metaraminol. Because noradrenaline is a naturally-occurring hormone, it is often favored and frequently a response occurs with this drug when all other vasopressors fail. The vasopressor must be administered at a rate that will keep the blood pressure just slightly below the patient's normal value. The complications associated with vasopressor therapy include the necessity for frequent blood pressure recording, the chance of overloading the circulatory system with a large fluid volume, and the complacence that may occur when the blood pressure is restored to normal. All these risks are negligible if the physician is attentive. Skin necrosis associated with prolonged noradrenaline therapy can be treated by the local injection of five mg. of phentolamine or by the installation of a similar dose into each 1,000 ml. of intravenous fluid. This dose of phentolamine in the intravenous bottle does not prevent the vasopressor effect of the noradrenaline, but completely annuls the risk of tissue necrosis, even if the fluid is extravasated interstitially in large amounts.[8]

Once these measures have been instituted the patient must be observed closely, a careful

record being kept of the blood pressure and urinary output. The urinary output is particularly important because it is a measure of the adequacy of peripheral blood flow. If the blood pressure cannot be maintained, or if the urinary output is not adequate, further therapeutic measures must be immediately initiated.

If the patient's condition is still not satisfactory, large doses of intravenous hydrocortisone are given. Pharmacological doses are employed with the intention not of replacing the adrenal cortical output of hormones but of blocking an allergic or hypersensitivity response to the toxin. The dose is 300-500 mg. of hydrocortisone every eight hours for three to five days.

At the same time, if either oliguria or cyanosis caused by poor peripheral circulation is present, then one can be certain that ischemia of the peripheral tissues and metabolic acidosis exist. This will inevitably lead to failure of the peripheral resistance and of the myocardium. Therefore, sodium bicarbonate is added to the intravenous infusion to restore acid-base balance.

A few other measures can be utilized. Elevation of the legs will improve venous return. Because heart failure is a factor late in all forms of shock, digitalis may be employed in resistant cases. Blood, plasma substitutes, and electrolyte solutions should be given only to replace measured losses: in the absence of evident loss, only 500 cc. of one of these solutions should be used as a therapeutic trial. Massive fluid therapy may lead to pulmonary edema. Oxygen therapy is probably of little benefit because the arterial oxygen content is usually normal, cyanosis being due solely to peripheral stagnation.

Other agents that have been employed include sympathetic blocking agents, antihistamines, and hypothermia. In septic shock the peripheral resistance is usually low, so the blocking agents are rarely required and may markedly lower the aortic pressure and the coronary and cerebral blood flow. Although histamine has been indicted as a factor in the tissue response to endotoxin, it is apparently released locally or within the cells and the administration of antihistamines has not altered the survival rate in experimental animals. Once septic shock has been established, hypothermia has been harmful both to patients and to animals. While it might be reasoned that the rate of bacterial proliferation would be diminished by the hypothermic state, this has not uniformly been the case under experimental conditions. At times, hypothermia actually impairs the defence mechanisms of the animal rather than the rate of bacterial proliferation.

Summary

Septic shock is a state of hypotension caused by bacteremia and associated with poor peripheral blood flow, as evidenced by oliguria.

The cardinal warning signal of the possible development of septic shock is a shaking chill.

In the treatment of septic shock, time is the most precious commodity that is available to the physician. The cornerstones of therapy are intravenous antibiotics and vasopressor drugs. In the absence of a favorable response as measured by blood pressure and urinary output, massive doses of intravenous hydrocortisone are administered along with sodium bicarbonate to correct the metabolic acidosis.

References

1. Crowell, J. W. and Guyton, A. C., *Evidence Favoring a Cardiac Mechanism in Irreversible Hemorrhagic Shock.* Amer. J. Physiol., *201*: 893, 1961.

2. Gurd, F. N., ed., *A Symposium on Shock.* J. Trauma, *2*:355, 1962.

3. Hall, W. H. and Gold, D., *Shock Associated with Bacteremia.* A.M.A. Arch. Int. Med., *96*:403, 1955.

4. McKay, D. G., Jewett, J. F., and Reid, D. E., *Endotoxin Shock and the Generalized Schwartzman Reaction in Pregnancy.* Amer. J. Obstet. Gynec., *78*:546, 1959.

5. Seeley, S. F. and Weisiger, J. R., eds., Proceedings of a Conference on Recent Progress and Present Problems in the Field of Shock. Fed. Proc., Vol. 20, Suppl. 9, July, 1961.

6. Spink, W. W. and Vick, J., *Evaluation of Plasma, Metaraminol and Hydrocortisone in Experimental Endotoxin Shock.* Circulation Res., *9*:184, 1961.

7. Weil, M. H., MacLean, L. D., Visscher, M. B., and Spink, W. W., Studies in the Circulatory Changes in the Dog Produced by Endotoxin from Gram-Negative Microorganisms. J. Clin. Invest., *35*:1191, 1956.

8. Zucker, G., Eisinger, R. P., Floch, M. H., and Singer, M. M. *Treatment of Shock and Prevention of Ischemic Necrosis with Levarterenol-Phentolamine Mixtures.* Circulation, *22*:935. 1960.

Paroxysmal Ventricular Fibrillation

WILLIAM R. GRAY, M.D.

Louisville, Ky.

A plea is made for prompt electric defibrillation and pacemaker therapy in this frequently fatal condition since drug therapy is usually disappointing when it is due to ischemic heart disease.

FOR MANY years ventricular fibrillation has been recognized as a terminal event associated with death but in recent years the paroxysmal form of this malady has achieved well deserved recognition as a pathogenetic mechanism of recurrent Stokes Adams seizures. Four cases of Stokes Adams syndrome in which the underlying mechanism was proved either by electrocardiograms or by oscilloscope monitor to be due to recurrent ventricular fibrillation will be presented in order to emphasize that the frequency of its occurrence is probably greater than many practicing physicians realize. This mechanism has been difficult to document in past years because of inadequate electrocardiographic monitoring but the more widespread use of constant oscilloscope monitoring should ease this technical difficulty. Clinical observations concerning diagnosis, management and prognosis will also be discussed.

Case Reports

The first case in this series was a 60-year-old white female housewife who was hospitalized in August 1949 with no cardiac symptoms until the day prior to admission when, while opening a garage door she suffered a sudden faint with loss of sphincter control, pallor and diaphoresis. She was noted by her family physician to have premature contractions subsequent to the attack and quinidine sulfate in maintenance dosage was prescribed. However a similar syncopal episode occurred 24 hours later, after which hospitalization was advised. Upon arrival at the hospital the third episode occurred, during which she was noted to be pulseless. An admission electrocardiogram after the episode showed a sinus rhythm with multifocal ventricular premature contractions and no evidence of acute infarction or atrioventricular block. During the following few days many subsequent attacks occurred and extensive electrocardiographic monitoring revealed the mechanism of recurrent ventricular fibrillation. Treatment included quinidine sulfate in doses up to 80 grains per twenty-four hours, papaverine, phenobarbital, magnesium sulfate I.V. and finally I.V. Novocaine. Procaine amide was not commercially available at that time. The patient expired in an episode on 9/6/49, seven days after admission and on post-mortem examination was found to have coronary arteriosclerosis and myocardial fibrosis but no evidence of recent infarction.

The second case, hospitalized in May 1954, was a 72-year-old white female with the history of three syncopal episodes during the 24 hours prior to admission. After admission an electrocardiogram during an episode revealed ventricular fibrillation to be present and therapy with quinidine, atropine and I.V. magnesium sulfate p.r.n. was begun. Because of a recurrent episode procaine amide was substituted for quinidine after 24 hours. At this time it was learned that she had been recently digitalized because of dyspnea and orthopnea but that nausea and irregular pulse had necessitated discontinance of digitalis two days prior to onset of seizures. Potassium chloride was added to the regimen thirty-six hours after admission and no further seizures occurred. A subsequent electrocardiogram showed left ventricular hypertrophy and digitalis effect but no evidence of infarction. She was discharged nine days after admission and suffered no known recurrence during the remaining year and a half of her life.

At this point a few words about the etiology should be presented. Ischemic heart disease would be the most logical etiology in the first

†*Presented before the September 25 meeting of the Kentucky Chapter of the American College of Physicians during the 1963 KSMA Annual Meeting in Lexington, Ky.*

**Clinical instructor in medicine at the University of Louisville School of Medicine, Louisville, Ky.*

case but possibly digitalis intoxication should be considered to be primary in importance in the second case. A review of the literature cites other causes of ventricular fibrillation including quinidine toxicity, which should also be considered in the first case, anesthesia, hypothermia, electrocution, lightning, coronary occlusion, open heart surgery and heart block. In past years it was widely held that patients with Stokes Adams seizures manifesting varying degrees of A-V block during intervals between their episodes probably suffered from cardiac standstill as the cause of their attacks. However it is now known that high grade A-V block is frequently found during symptom free intervals in Stokes Adams patients with recurrent ventricular fibrillation—a situation which is illustrated by the third case.

This 78-year-old diabetic housewife was first seen in April 1953 with a Stokes Adams attack and complete A-V dissociation on electrocardiographic examination. Subsequently she maintained third degree A-V block with a ventricular rate of 38-44 beats per minute and suffered one or two syncopal episodes per year until April 1961, when a half dozen episodes occurred within one week. Her medication had been taken regularly and had included atropine, sublingual isoproterenol, phenobarbital and Orinase. After failure to respond to adjusted doses of medication at home she finally consented to hospitalization where a monitoring oscilloscope showed the mechanism to be paroxysmal ventricular fibrillation. Since conservative therapy was ineffectual in controlling the seizures she underwent thoracotomy for installation of an electronic pacemaker. During the two and one half years since this procedure she has suffered no additional seizures although a broken wire has allowed her ventricular rate to drop into the low forties on three occasions. At this writing she has mild congestive heart failure but is otherwise doing well.

The fourth case was a 52-year-old white male who was hospitalized by his family physician in July 1961 because of four "blackouts" within a period of twenty-four hours. He was found to have complete A-V dissociation and was started on isoproterenol. The seizures continued after admission in spite of increasing doses of isoproterenol and atropine with the recording of paroxysmal ventricular fibrillation on the electrocardiogram on several occasions during seizures. Addition of procaine amide to the regimen seemed to increase the frequency of attacks. An electronic pacemaker was then installed and the seizures did not recur. He died fifteen months later following protracted chest pain, presumably from acute myocardial infarction.

The typical symptomatology is that of sudden syncope accompanied by marked pallor and sometimes immediately preceded by palpitation by which the patient could predict the onset of fibrillation before losing consciousness. If cerebral anoxia is sufficiently prolonged, convulsive seizures, incontinence and even death may occur. If the attack is terminated spontaneously immediate flushing of the skin occurs and consciousness soon follows usually without permanent neurological sequelae. As implied earlier in this presentation the diagnosis depends on suspicion of the fibrillatory mechanism as the cause of Stokes Adams seizures followed by persistence on the part of the physician in confirming its presence by electrocardiographic or oscilloscopic monitoring. Establishing the correct diagnosis is especially important since the common practice of giving epinephrine to treat Stokes Adams attacks would be contraindicated when paroxysmal ventricular fibrillation exists.

Discussion

The mechanism of production of ventricular fibrillation remains uncertain. Wiggers[1] showed that ischemic myocardium repolarizes before normal myocardium, thus setting the stage for reentry and possibly the onset of ventricular fibrillation. Recently Lown[2] and associates have demonstrated that direct current stimulation applied during a 30 millisecond period near the apex of the T wave causes ventricular fibrillation in a large percentage of cases just as stimulation during the terminal portion of the QRS produces atrial fibrillation in a large percentage of cases. Since electrocardiograms just prior to the onset of paroxysmal ventricular fibrillation frequently show multifocal ventricular premature contractions it is conceivable that one of these stimuli could occur during the vulnerable fibrillatory zone of ventricular repolarization thus initiating the paroxysm of fibrillation. Another theory proposed by Brofman, Leighninger and Beck[3] emphasizes the likelihood of origin of ventricular fibrillation in an ischemic myocardial trigger area where a significant differential in the oxy-

genation of adjacent normal and ischemic myocardium exists. However Badeer[4] disputes this type of reasoning on the basis of his experimental work with dogs in which administration of 100% oxygen after ligation of a coronary artery was used to increase the oxygen tension of well perfused areas of myocardium and in which no significant increase in the development of ventricular fibrillation was noted to occur over that group of dogs ventilated with room air only. Other theories as to pathogenesis are the circus movement theory and the rapid ectopic focus theory which have been more widely publicized in the study of atrial fibrillation. Even though there is lack of agreement as to the actual pathogenetic mechanism of development of the ventricular fibrillation, the common denominator seems to be either an anoxic myocardium or one which has been affected by certain toxic substances.

The difficulties inherent in the diagnosis and proper management of this condition challenge the physician especially when he is mindful of the ever-present possibility that the attack may not spontaneously cease and that death may occur. It should be emphasized that the three to four minute deadline for safety in preserving normal central nervous system function makes manadatory immediate emergency measures such as external cardiac massage, establishment of adequate pulmonary ventilation, etc. If the episode does not terminate spontaneously electrical defibrillation should be performed as soon as possible.

During the acute episode drug therapy alone is of no value and is disappointing in preventing recurrent attacks of ventricular fibrillation in most cases. This disappointment in drug therapy is reflected in the medical literature by the conflicting articles, one of which praises a certain drug while another condemns it. Myocardial depressants such as quinidine, procaine amide and magnesium sulfate have been advocated in past years but have also been blamed as being responsible for increasing the frequency of attacks by further depressing an already depressed ischemic myocardium. It is generally held[5,6] that complete A-V heart block is a definite contraindication to the use of such depressant drugs. The opposite or stimulating approach in drug therapy is exemplified by the positive chronotropic action of isoproterenol which in theory should improve coronary perfusion and myocardial oxygenation but in reality may increase myocardial irritability. This was probably true in cases three and four which showed an increased frequency of attacks as isoproterenol dosage was increased. If digitalis toxicity is causative then withdrawal of the drug and administration of potassium salts and/or chelating agents should be helpful. Other drugs used in treating heart block with Stokes Adams attacks are corticosteroids, thiazide diuretics and molar lactate but these have not been evaluated in this series of cases due to ventricular fibrillation. Drugs such as reserpine and guanethidine which affect the catechol amines were also not evaluated in these cases. In cases where ischemic heart disease is the etiology the most effective treatment would seem to be electric defibrillation, possibly combined with some type of external or internal pacemaker, the permanency of which would depend on the reversibility of factors causing the recurrent ventricular fibrillation. Pacemakers are now available which may be permanently implanted entirely beneath the skin, thus preventing the danger of infection which obviously is present when a wire leading to the myocardium goes through the skin. Also available are temporary pacemakers which may be used to stimulate the right ventricular endocardium via an electrode inserted into either an antecubital or external jugular vein.

The prognosis depends on the etiology and other associated pathology but is poor in most cases. This grave outlook without drastic treatment justifies early definitive and dramatic measures since conservative management and delay may be fatal. Worthy of repeated emphasis is the fact that when ventricular fibrillation due to ischemic heart disease is recurrent, drug therapy is usually ineffectual and prompt electric defibrillation and pacemaker therapy is mandatory.

Summary

The subject of recurrent ventricular fibrillation and four illustrative cases have been presented and discussed as to etiology, diagnosis, pathogenesis, management and prognosis. Immediate cardiac massage,[7] pulmonary ventilation, electric defibrillation and pacmeaker therapy are imperative if the patient is to live.

Bibliography

1. Wiggers, H. C. & Wiggers, C. J. Ventricular Action Cur-

Continued on Page 637

CASE DISCUSSIONS
From The
University of Kentucky Hospitals

Extensive Carcinoma of the Duodenum Treated by Pancreatico-Duodenectomy and Right Hemicolectomy

J. A. Gallagher, M.D., H. Tesluk, M.D. and F. C. Spencer, M.D.*

Introduction

THIS report describes an unusual operative experience with a 43-year-old patient with a large carcinoma of the duodenum invading the mesentery of the colon. Though the tumor was a large one, a successful resection was still possible, however, by performing a pancreatico-duodenectomy and right hemicolectomy. Although over 600 cases of carcinoma of the duodenum have been reported, a resection of this extent has not been previously described.[4]

Case Report

W. R., a 43-year-old male, was admitted to the University of Kentucky Medical Center on December 30, 1963 because of nausea and vomiting for five months. This had resulted in a weight loss of 20 pounds. He also had persistent dull pain in the right upper quadrant and had noted frequent tarry stools. On abdominal examination, tenderness and muscle rigidity were found in the right upper quadrant, but no mass could be felt. He was not jaundiced, although the liver was palpable for 2 cm. below the right costal margin. Laboratory studies found an hematocrit of 18 percent, a serum bilirubin of 0.4 mg. percent, a bromsulphthalein retention of only 5 percent, and a plasma alkaline phosphtase of 12 units. The electrocardiogram, barium enema, intravenous pyelogram, and chest roentgenogram were all normal. Barium studies of the stomach and duodenum, however, showed a filling defect in the second portion of the duodenum with distortion of the mucosa suggesting malignant infiltration (Fig. 1).



Figure 1. Lateral view of gastro-intestinal series shows gross mucosal deformity of second portion of duodenum from the neoplasm.

Following transfusion of 3000 ml. of blood, a laparotomy was performed on January 6, 1964 through a long midline incision. A large mass was found in the second portion of the duodenum which was adherent to the mesentery of the hepatic flexure of the colon. A lymph node in the mesocolon in this area was found to contain adenocorcinoma when histologic examination was performed by frozen section. Preliminary dissection was begun in the gastrohepatic ligament, mobilizing the hepatic artery and dividing the gastroduodenal artery at its origin. The portal vein in this area showed no involvement by tumor. Dissection was accordingly performed at the inferior border of the pancreas where the superior mesenteric vessels were mobilized. Palpation along the superior mesenteric vein upwards to its junction with the splenic vein to form the portal vein posterior to the pancreas demonstrated that there was no involvement of the portal vein. Excision of the tumor was then decided upon, though obviously the right colon had to be removed. The subsequent excision then removed the head of the pancreas, about 30 percent of the stomach, the gall bladder and distal common duct, the entire duodenum, and the right half of the colon. Excision was accomplished without difficulty, following which the transsected end of the pancreas was implanted into the end of the jejunum. About 5 cm. beyond the pancreatic implantation, the common duct was anastomosed as an end-to-end anastomosis to the jejunum over a "T" tube. Six inches distally the gastrojejunostomy was per-

*From the Departments of Surgery and Pathology, University of Kentucky Medical School, Lexington, Kentucky.
*Supported by the Fred Rankin Surgical Fund.

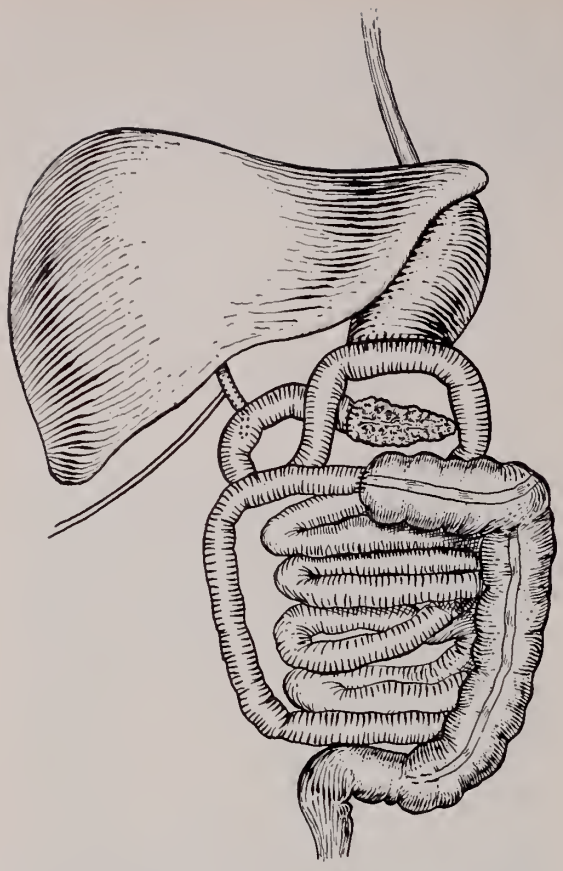


Figure 2. Following excision of the tumor, the pancreas was implanted into the end of the jejunum. About six inches distally, the common duct was anastomosed to the jejunum over a T-tube. A gastro-jejunostomy and ileotransverse colostomy completed the reconstruction.

formed. An ileotransverse colostomy completed the operative procedure. (Fig. 2)

The postoperative course was uncomplicated, and by the fifth postoperative day the patient was eating normally. Subsequently the "T" tube was removed, following which he was discharged on the eleventh postoperative day. In May, 1964, four months following operation, he was asymptomatic and eating normally. He had gained 15 pounds in weight.

Pathologic findings. Examination of the surgical specimen in the surgical pathology laboratory found an ulcerating 5 x 8 cm. tumor in the second portion of the duodenum. The ampulla of Vater was located at the proximal border of the neoplasm. There was no obstruction to either the common duct or the pancreatic duct. Much of the tumor was superficial to the muscularis of the duodenum, but in some areas it penetrated to the underlying pancreatic tissue (Fig. 3). The entire tumor mass measured 8 x 10 cm.

Microscopic examination found an anaplastic carcinoma producing mucus. In some areas there was a partial formation of acini or alveoli (Fig. 4). Numerous mitoses were present. The tumor had invaded the pancreas and the regional lymph nodes by difect extension. Fifteen separate lymph nodes were examined, only one of which contained tumor. The differential diagnosis included islet cell carcinoma, argentaffine carcinoma, and carcinoma of the pancreas. The location of the gross neoplasm, the partial formation of acini, and the formation of mucus all supported the diagnosis of adenocarcinoma of the duodenum.



Figure 3. A microscopic low-power view of the discrete margin of the tumor in the wall of the duodenum. In this area it is still confined to the mucosa and submucosa.

Discussion

Clinical considerations. Though carcinoma of the duodenum is an uncommon neoplasm, over 600 cases have been reported since its first description by Hamburger in 1746[2]. The lesion is an adenocarcinoma arising from the duodenal mucosa. Interesting enough, the duodenum, though a comparatively short segment of the total amount of small intestine, is involved by approximately 45 percent of all of the carcinomas of the small intestine.[5] All portions of the duodenum are involved with equal frequency. The tumors infiltrate adjacent tissues and also quickly involve regional lymph nodes.

The most frequent presenting symptoms, occuring in over one-half of the patients, are nausea and vomiting from small bowel obstruction. Unfortunately these symptoms develop slowly because the fluid content of the duodenum makes signs of obstruction appear only after extensive involvement by tumor. Bleeding, often only as melena, is also frequent, occurring in about one-third of the patients. Pain, usually

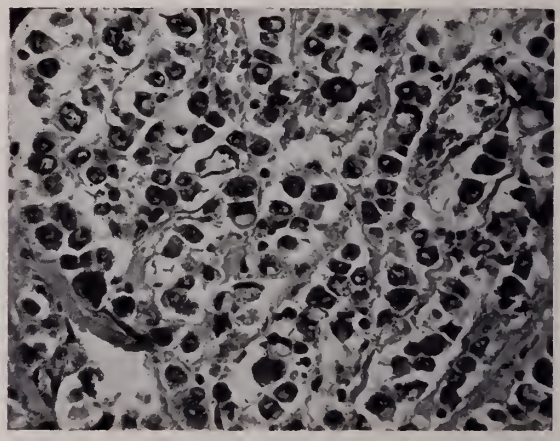


Figure 4. A microscopic high-power view of the tumor shows that the cells are poorly differentiated but still have some secretory activity.

from local invasion, is a late and infrequent symptom, being found in only about 10 percent of the patients. As the ampulla of Vater is often not involved, jaundice is uncommon.

On physical examination, the tumor mass is often palpable because it frequently becomes large before symptoms develop. The most significant diagnostic study is a roentgenologic study of the duodenum which will show obstruction and mucosal deformity.[1] The differential diagnosis by the radiologist includes benign tumors of the duodenum and carcinoma of the pancreas. Pancreatic neoplasms distort and widen the duodenal loop, however, without actual destruction of the mucosa. In the patient reported here, the correct diagnosis was suggested by the radiologist.

Therapeutic considerations. As symptoms often first appear when the tumor has become large and invaded adjacent tissues, resection has been possible in only 20 to 25 percent of patients. Without excision the prognosis is poor, for inoperable patients seldom survive more than 12 to 18 months. Five year cures following resection also have been limited because of extensive local invasion. Some authors have reported no five year survivals while Warren has reported the best results with a 40 percent five year survival (Table 1).

Table 1
Reported Operative Experiences With Carcinoma Of Duodenum

Authors	Year	Number of Cases	Number of Resectable Lesions	Operative Mortality	Five-Yr. Survival
Brenner[2]	1955	15	8	0%	0%
Porter[7]	1958	9	5	0%	40%
Warren[9]	1962	27	27	18%	40%
Spinazzola[8]	1963	12	4	0%	25%
Monge[6]	1964	8	7	12%	14%

The large mass invading the colon in this patient could easily have led to the conclusion that resection should not be attempted. Though the anaplastic histologic picture of the neoplasm indicates a poor prognosis, several factors indicate that resection should have been performed. First, the common duct was not involved, as indicated by the absence of jaundice. This indicated that the tumor was limited to the portion of the duodenum distal to the point of entry of the common duct. Second, the absence of involvement of the portal vein indicated that resection was f e a s i b l e. The mortality from pancreaticoduodenectomy has steadily decreased in recent years to where at present it is less than 10 per cent in good risk patients. With the good nutritional state of this patient and the relatively young age of 43 years, the risk of resection was probably less than 5 percent. Without excision his outlook was poor for both survival and symptomatic relief, as he was disabled from both abdominal pain and vomiting. The results following palliative treatment, such as gastroenterostomy, have been disappointing, most patients continuing to have pain and remaining uncomfortably disabled before succumbing within a few months. By contrast this patient has been asymptomatic and eating normally since operation. He has shown no signs of pancreatic insufficiency.

Summary

A 43-year-old patient with an extensive adenocarcinoma of the duodenum invading the mesentery of the colon was treated with pancreatico-duodenectomy and right colectomy. In the four months since operation, he has been eating normally, has gained 15 pounds, and is free of symptoms. In the 600 patients with carcinoma of the duodenum reported in the surgical literature, this is the first such patient found in which it was possible to remove successfully the tumor by combining a partial colectomy with a pancreatico-duodenal resection.

References

1. Barclay, T. H. C. and H. P. Kent: *The Diagnosis of Primary Tumors of the Duodenum;* Gut 3:49, 1962.
2. Brenner, R. L., and Charles H. Brown: *Carcinoma of the Duodenum—Report of 15 cases;* Gastroenterology 29:189, 1955.
3. Higgins, D. C., Judd, E. S., Dockerty, M. B.: *Surgical As-*
4. Iovine, V. M. and N. Tsangaris: *Primary Carcinoma of the pects of Infrapapillary Duodenal Tumors;* Surgery 49:149, 1961. *Duodenum;* American Surgeon 27:744, 1961.
5. Jordan, G. L. and M. E. DeBakey: *Malignant Neoplasms of the Duodenum;* Surgery 42:829, 1957
6. Monge, J. J., Dockerty, M. B., Wollaeger, E. E., Waugh, J. M., and Priestly, J. T.: *Resection For Peripapillary Carcinoma;* Surg. Gynec. and Obstetrics 118:275, 1964.
7. Porter, M. R.: *Carcinoma of the Pancreatico-Duodenal Area;* Ann. Surg. 148:711, 1958.
8. Spinazzola, A. J. and W. J. Gillesby: *Primary Malignant Neoplasms of the Duodenum;* American Surgeon 29:405, 1963.
9. Warren, K. W., Cattell, R. B., Blackburn, J. P., Nora P. F.: *A long-term Appraisal of Pancreatico-Duodenal Resection for Periampullary Carcinoma;* Ann. Surg. 155:652, 1962.

A special treat is in store for you—

Hear Doctor Charles Jarvis,

One of the outstanding humorists of our time, at the

President's Luncheon, Wednesday, September 30

Terrace Room, Kentucky Hotel

SPECIAL ARTICLES

Doctor Pope and His Building

RUTH ATWOOD*



Curran Pope, M.D. 1866-1934

THE early 1890's were busy times for the 100 block of Chestnut Street. In 1893 the Neo Romanesque towers of the Louisville Medical College formed a new landmark, and in 1894 a handsome red brick structure was erected at 111 Chestnut by Curran Pope, M.D.[1] Doctor Pope not doubt felt at home on Chestnut Street; he was on the faculty of the Louisville Medical College as Professor of Mind and Nervous System, and since his return from Europe in 1891 he had had offices on the street at number 100 and 104.

Doctor Pope was a member of a prominent Louisville family, which claimed decent from the famous English poet Alexander Pope. His father was a judge and noted for his public spirit. Curran was educated at Rugby School and Male High in Louisville. After a short venture into business, he turned to medicine as a career and completed the course offered by the University of Louisville School of Medicine in 1889. Postgraduate training at New York Polyclinic was interrupted by a six month stay at Central Hospital at Lakeland, where he held the post of staff physician. He then went abroad for further postgraduate training. He attended Queens-Square Hospital for the Paralyzied and Epileptic in London, and the General Hospital in Vienna, under Kraft Ebing, studied under Professors Weigert and Edinger in Frankfort, and under the world famous Doctor Charcot in Paris.[2] It is probable that his life-long interest in hydrotherapy began during this European training. When he first returned to Louisville he began private practice in two small rooms at 100 Chestnut Street. In 1893 he was at 104 in a building also occupied by the Eliza Grover Kindergarten and the Louisville College of Pharmacy. At this time he also became demonstrator of histology, bacteriology and clinical microscopy at the Hospital College of Medicine. By 1894 his private practice had grown, and he had become Professor of the Mind and Nervous System at the Louisville Medical College.

On July 8, 1894, Doctor Pope purchased a tract of land situated on the north side of Chestnut between 1st and 2nd Street, immediately east of, and abutting upon the alley which runs northwardly from Chestnut Street between 1st and 2nd, 30 feet from Chestnut, and back on said alley to a line 10 feet distant from and parallel with, the south line of the female high school. He paid $2,340 for the property to the Louisville Trust Company Committee representing the interests of T. H. Dudley, "a lunatic."[3] He was perhaps unaware of, or uninterested in, the existence of a strip six feet nine inches wide adjoining the property also inherited by T. H. Dudley from his relative, Christopher Dudley. A strip of land later to cause great difficulties for the University of Louisville.

A picture of the building Doctor Pope erected on his newly purchased property appears in an advertisement for the Sanatorium in 1897[4]; it is instantly recognizable as the Pope Building of today, although the bricks are at present somewhat grimier and the large tree has been replaced by a crowded parking lot. Doctor Pope's modern Sanatorium was well equipped with apparatus for the most advanced electrical and hydrotherapeutic treatment; he was considered a pioneer in these measures in America. In 1909 he published an authoritative work on this area, *Practical Hydrotherapy*. Present day readers may find some of the

Senior Librarian for Public Services, Kornhauser Memorial Medical Library, University of Louisville School of Medicine.



The Pope Building 1897

views on treatment quaint as in the discussion on cold baths.

> "There should be no evidence of faint-heartedness or lack of confidence in the application of this bath by the nurse or physician, should he be a bystander, and it is a good rule for the physician to always be present at the first bath. all members of the family must, if possible, be excluded from the room. The patient is now gently lifted from the bed and placed in the bath. Here, as in many of the positions in which a physician is placed, tact will accomplish wonders. My observation, however, leads me to believe that the family are, as a rule, more difficult to manage than the patient, as they are usually strangers to cold water in their daily ablutions, and share with the patient the feeling of repulsion."

Throughout the work, however, there is a spirit of concern for the patient that measures up to medicine's highest standards, as in his discussion of drug addiction:

> "Has it ever occurred to you that these people have been the outcasts of medicine, without hope, spurned and derided as lacking in all the higher mental and moral traits? To give them hope is to give them courage, and I say candidly and advisedly to not recognize them as diseases is to reflect upon the intelligence and capacity of those who make the statement. Let us give them hope, the greatest of all stimulants, and a gift that the Deity has offered unto all mankind. Be not uncharitable to their faults and sufferings, deal kindly, thoughtfully and patiently with them, and you will become their anchor of hope. Rob them of this and their strength and vigor are gone; with it they fight the battle better and more gloriously. It has always seemed to me that one of the essential features of the treatment of this class of cases is the physician himself."[6]

There was no licensing or inspection of sanatoriums at that time, and abuses were frequent. The scrap book of the Jefferson County Medical Society contains an account of one such unscrupulous rascal.[7]

> "Dr. John A. Taft, who conducts a sanatorium on Third Avenue was presented in Police Court this morning on a charge of practicing his profession without a license. The real purpose, however, of the board was to establish the character of the sanatorium, and that, instead of curing patients, Taft had called on a physician to attend a patient who was almost beyond human aid. . . . The alleged Dr. Taft had conducted sanatoriums on the same plan in Washington, and when a patient had suddenly died under mysterious circumstances, Dr. Taft left the City between two suns."

Doctor Pope's ethics, however, were of the highest possible kind. Those who knew him referred to him as "a gentleman of the old school."[8] He was indignant when a promoter seeking to build up Chestnut Street Business inserted an advertisement of the Sanatorium in a little scorecard to be passed out at the Colonels' baseball games. He forced the promoter to destroy many of the copies already printed and remove his name from all future cards.

Doctor Pope was a great joiner, and his correspondence was filled with requests for membership in societies, and later, with details concerning numerous speaking engagements. He was a member of innumerable socieities, ranging from the American, Kentucky, Southern, Ohio Valley Medical Associations to the Shriners, Loyal Legion and Elks. One rather distressing experience came as a result of this penchant. In 1916 he joined the Medical Society of the United States, a new society started by Doctor Emory Lamphear of St. Louis, an acquaintance of Doctor Pope. In fact, he was elected a vice-president of the organization at its first meeting, which he had not attended. This group was in disrepute with the A.M.A. as it advocated fee splitting, a practice the A.M.A. has always sought to eradicate. Doctor Pope was ignorant of this, until he received a letter from Alex Craig, secretary of the A.M.A. expressing great surprise at finding his name on the membership list. He immediately wrote Doctor Lamphear in great indignation:

Dear Dr. Lamphear,

I joined this society upon your personal request and you had no right to use my name in any way without my sanction. I cannot subscribe to your ethics and will therefore ask you to immediately remove my name from the membership and that you in no wise use it in any connection whatsoever with this association. I am at a loss to understand why you should have placed me in this position for you had no right to do so. In order that this letter may reach you I have registered it and trust you will not delay in complying with my request and giving me some exing with my request and giving you some explanation of your action.

Sincerely,

Doctor Lamphear replied in a righteous tone on November 8, 1916.

Dear Curran:

Somebody is spending a hell of a lot of time, trouble and money "knocking" our new medical society. The society has never endorsed "division of the fee." I sent out a few letters to men whom I knew favor the plan asking them to join as the society would not condemn them for holding such views and some of the state journals have been howling about it. . . . The organization committee selected you for the Vice-President for Kentucky. . . . In accordance with your request your name will be dropped from this position. . . .

Sincerely,

Believing his connection with the association severed, Dr. Pope was irate to receive on January 9, 1917 a bill for dues. He immediately wrote to Dr. Lamphear, again requesting removal of his name. Dr. Lamphear's reply of January 11, 1917 is quite amusing:

Dear Dr. Pope,

Your previous letter did not say anything about resigning, but since you wish it I will see that your name is dropt from the list. I am exceedingly sorry Craig's letter made such an impression on you. However, those who haven't the guts to tell Craig and "de gang" to go to perdition are not sufficiently enthusiastic about the new society to be of much value to it. I regret that you cannot feel yourself to be an absolute independent. With very good wishes for the new year I am,

Sincerely,[9]

Even in 1916 it was advisable to look before you joined. However, this episode, though distressing, was a minor one. Doctor Pope continued his busy practice and his writing and lecturing, and holding various offices in many of the organizations he belonged to.

With the Depression unfortunately Doctor Pope's life, along with the lives of many other Americans, was darkened with financial troubles. He was known as a doctor who never pressed his patients for payment. His speculations met with the fate of most speculations in the 1930's and on January 28, 1932 he borrowed $10,000 from Raymond E. Haymond, M.D., a physician who had been associated with Doctor Pope in the sanatorium for some years. Doctor Pope signed a note pledging payment at 6% interest in one year and putting up the Pope Building as collateral.[10] His attempts to recoup his fortunes failed, and on October 16, 1933 Doctor Haymond foreclosed.[11] Doctor Pope continued to operate the sanatorium, although he was handicapped by a broken hip which rendered him a semi-invalid. On September 21, 1934 he was found dead in his room on the second floor. He had fired a bullet into his mouth. On his bed a mystery novel entitled The Murder of Sleep was found open. His nurse, Mrs. Joseph Hounsfield, had said goodnight to him at 11 the night before and said he was in a cheerful mood. At 1:30 she heard a muffled shot. She decided, after a moment, it was outside the building, an indication of the character of the neighborhood then. The coroner's verdict was suicide.[12]

Doctor Pope's will first provided for care of his grave at Cave Hill next to his brother, Alfred Thurston Pope. To the Jefferson County Medical Library he left his medical books, (still in the present Library's collection) and the sum of $100.00 for the purchase of new texts in neurology and psychiatry. The Louisville Free Public Library received the rest of his books. To the Speed Museum furniture, bronzes, and bricabrac from his home for an exhibit. His large collection of stick pins, watch fobs, and trinkets was to be divided among twelve of his men and women friends. He desired provision made for a small annuity to two of his faithful servants. The residue, including his house at 225 East Walnut was to establish at a suitable institution, University of Kentucky, University of Louisville or Berea, a building to bear his name and to be erected not for beauty but for utility in educating students along scientific lines.[13] Unfortunately none of these bequests were ever made. The trust company was able to salvage a few dollars for the servants, but the stick pins, the trinkets, the house and furniture were not enough to cover his debts.[14]

After Doctor Pope's death the sanatorium was operated for a short period by John C. Rogers, Jr., M.D., who had been associated with Doctor Pope, and Doctor Rogers' son and daughter-in-law. But business in the Depression was not at all brisk. Patients were few and payments difficult to get from these few patients. In 1938 the University of Louisville purchased the sanatorium from Doctor Haymond for $12,500.00[15] and continued to operate it as a sanatorium. In 1941 the University needed rooms for the students, and the operators of the Sanatorium were in arrears in the rent so the University repossessed it and ran it as a dormitory through World War II. At this time, the University was also approached by the owner of the six foot nine inch strip of land next to the Pope Building. In 1922 Miss Mary E. Hayes had purchased that strip for back taxes which H. T. Dudley had neglected to pay.[16] She asked $1,000.00 for it and was refused.[17]

After World War II the need for laboratory space was so urgent that the University appropriated $30,000 for remodeling the Pope Building, and it became the quarters of the Institute for Medical Research.[18] The University also built a passageway connecting the Pope Building with the annex of the Medical School across the disputed six foot nine inch strip. Mrs. Mary Pascale (neé Hayes) thus had a forceful argument for sale when she again approached them in 1949, asking $4,000. After considerable dickering, the University purchased the property for $1,300. Both sides were pleased. The University had gotten Mrs. Pascale down from her top price of $4,000 to $1,300 and she had gotten $1,300 for the property she had acquired for $6.08.[19]

The Pope Building is now used for research and teaching by the University of Louisville Medical School. Although many of the provisions of Curran Pope's will were not fulfilled, the most important ones were. He lies buried between his brothers on a grassy knoll at Cave Hill, the simple dignified stone over-

Continued on Page 630

EDITORIALS

For A Better Kentucky

THE Medical profession traditionally concerns itself with the health care of the people. An unprecedented increase and modernization in medical facilities has taken place in the last generation. The advance in medical and surgical techniques, the accomplishments in preventive medicine, the expansion of medical education, the extension of interest and teaching to other countries, our support of world health organizations; these and innumerable other achievements acclaim that American physicians are alert and are making great progress in our field.

Could we confine our concern to health affairs alone our responsibilities would be less complex. In addition to being physicians we our citizens. As well educated and informed members of the community we are expected to share in the leadership toward a better life in general. We are asked, and rightly so, to participate in every good work by who-so-ever it is proposed and pushed.

The one organization which leads all others in it attention to civic progress and betterment is the Chamber of Commerce. The Kentucky chamber as an overall organization has in recent years of accelerated activity done much to advertise our state by the improvement of our living conditions, by the extension of highways to every section, and by helping to bring new industries and greater employment to our communities. The effect of this campaign has been felt in large and small industries, in our colleges and schools and in Tax revenue for the general good.

The Louisville, Lexington, Ashland and Owensboro Chambers of Commerce have been highly effective but their activity is duplicated by many of the smaller chambers throughout the state. They are by far the most aggressive and effective organizations for civic improvement that we have. Their study committees in the matter of eduaction, highway construction, sewer control, hospitalization, medical care, new industries, have accomplished wonders in recent years for the betterment of our cities and state.

No organization has been more constant in its support of private enterprise, the individual choice of physician and in upholding the morale and dignity of our profession than have the national and local chambers.

Physicians stand for progress — wherever they live they are rightfully accorded positions of leadership by reason of their superior training, experience, and vision. It would seem natural for them to always be aggressive members of their local and state Chamber of Commerce which are such effective organizations for community improvement. Admittedly the annual payment of dues is but a contribution to the achievement of better living for all; membership and activity but an effective moral support. Advantages cannot be readily measured in dollars or prestige but there is a reward for participation in good works which we as individuals can ill afford to miss.

SAM A. OVERSTREET, M.D.

The Records Show

THE Department of Health of Kentucky recently released the fifty-first annual Vital Statistics Report prepared from the birth, death and morbidity reports recorded for the calendar year 1962. The Report represents a great deal of work and the results will be of interest to many, including the physicians who act as health advisors and counselors to their fellow Kentuckians.

Unfortunately, it is not likely to be widely read by practicing physicians, many of whom have an aversion, dating back to medical school days, to anything concerning statistics. To the medical student, eager to get started in clinical medicine, the particular course having to do with medical statistics and statistical methods is apt to be a deadly bore. Yet these medical statistics influence every phase of our medical work from taking care of the individual patient to planning public health programs.

Suicides became one of the ten leading causes of death in Kentucky in 1962 for the first time in fifty-one years according to the report.

Deaths from motor vehicle accidents in creased 12.2 percent from 1961 to 1962. The greatest number of accidental deaths of all kinds occur in May, June, July and August.

Infant and maternal death rates declined slightly from 1961. The maternal death rate was down to 4.4 deaths per 10,000 live births from the 1961 rate of 5.7 maternal deaths. The infant dcath rate declined from 27.7 to 26.9 deaths for every 1,000 births.

The illegitimacy rate reached a level of 55.5 illegitimate births per 1,000. This is a 65.2 percent rise in illegitimacy since 1951.

Tuberculosis dropped from tenth place in 1961 to eleventh place in 1962 as a cause of death. Kentucky continues to have one of the highest rates in the nation.

The Report indicates that the reported cases of hepatitis more than doubled from 1952 to 1962. Out of 2,405 cases of hepatitis reported in 1962 there were 28 deaths. In spite of the era of antibiotics, people still die of pneumonia. Three percent of the 30,499 deaths in Kentucky in 1962 were due to pneumonia. Malignant neoplasms ranked as the second cause of death with 14.7 percent of the total.

Diseases of the heart and blood vessels accounted for 53.5 percent of all deaths and lead the list as they did in 1961. The problem of the cardio vascular diseases remains a tremendous one, but statistics recently released by the American Heart Association were encouraging. These figures indicated the first downward turn in the cardio vascular death rate among men aged 45-64 — a drop of six percent from 1950 to 1960.

For many years the death rate from cardio vascular disease among men aged 45-64 has been gradually going up in the United States. This trend finally appears to have been reversed.

With continuing effort and support by physicians and laymen we can entertain a reasonable hope for future reduction of most of the present major causes of death.

WALTER S. COE, M.D.

Plan to Attend

the

KSMA Annual Meeting

Sept. 29 - Oct. 1

Convention Center

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS



PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

PRO-BANTHĪNE (propantheline bromide) Assures Authoritative Anticholinergic Control in Gastrointestinal Dysfunctions

The clear and consistent therapeutic benefits of Pro-Banthīne (propantheline bromide) have made it the preferred anticholinergic for the past decade.

During that time, many compounds have been developed and proposed as alternatives. In the appraisal of Roach[1] ". . . few, if any, have seemed to offer a distinct improvement, . . ."

Early investigations showed that Pro-Banthīne (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthīne] and propantheline [Pro-Banthīne].

The name Pro-Banthīne (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE

Chicago, Illinois 60680

Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

ORGANIZATION SECTION

Diabetes and Athletic Injuries are Important Subjects of Panels To be Featured on KSMA Annual Meeting Scientific Program

Symposia on Diabetes and Athletic Injuries, both important areas of interest to all physicians, will be among the features planned for the scientific sessions of the 1964 KSMA Annual Meeting in Louisville, according to George P. Archer, M.D.. Prestonsburg KSMA president and chairman of the Council on Scientific Assembly.

In addition to the symposia, a Trans-Atlantic clinicopathological conference between outstanding obstetricians and gynecologists here and in England, will be another highlight of a program designed to be one of the most informative ever presented, Doctor Archer said. Douglas M. Haynes, M.D., Louisville, program chairman of the Annual Meeting this year, will moderate the Trans-Atlantic panel.

Doctor Archer recently released biographical information on four of the well-known speakers who will participate in the Annual Meeting as guests of various specialty groups. A complete roster of speakers will appear in the September Annual Meeting Issue of The Journal.

John R. McDonald, M.D., Detroit, professor of surgical pathology at Wayne State University, will take part in the KSMA annual meeting as the guest of the Kentucky Society of Pathologists. Doctor McDonald received his M.D., cum laude, from the University of Manitoba at Winnipeg, Canada, in 1933, and his M.S. in pathology from the University of Minnesota, Mayo Foundation, in 1936. Since that time he has held a number of positions with the Mayo Foundation, and at Wayne State. He is a fellow of the American Association for Thoracic Surgery, the American College of Chest Physicians, the College of American Pathologists and has held offices in many groups. "Current Theories of Carcinogenesis" will be the topic of his presentation before the general scientific session on Tuesday morning, September 29. That afternoon he will address his host specialty group on "Muscle Biopsy: Indications, Limitations and Interpretation."



Doctor McDonald

Trawick H. Stubbs, M.D., M.P.H., Atlanta, has been in his present position as director of the community Mental Health Service, division of Mental Health, for the Georgia Department of Public Health, since 1957. Doctor Stubbs, a 1940 graduate of Emory University, received his M.P.H. degree from Harvard School of Public Health in 1953. After serving for six years with the U. S. Public Health Service, Doctor Stubbs became assistant dean and associate professor of preventive medicine at Emory University.

Annual Meeting Issue Next Month

The September issue of The Journal of KSMA will be the official Annual Meeting Issue, featuring the entire scientific program with biographical information of all guest speakers, complete schedule of House of Delegates meetings, technical and scientific exhibits, U. of L. class reunions, and other important notices. Watch for your September Journal!



Doctor Stubbs

He has also been Dean of the Faculty of Medicine and professor of community health at the University of Missouri. Doctor Stubbs will speak to his host group, the Kentucky Psychiatric Association, on Wednesday, September 30, on the subject, "Psychiatry's Double Binds." On the previous day he will deliver a talk on "The Physician's Contribution to Emotional Wellness" before the general session.

The guest of the Kentucky Association of Public Health Physicians, Kenneth R. Byerly, associate professor of journalism at the University of North Carolina at Chapel Hill, will discuss "The Health Officer and His Public" before the Tuesday morning meeting of his host group. That afternoon Mr. Byerly's topic at the general scientific session will be "The Physician and the Press."



Mr. Byerly

Mr. Byerly is well versed in the areas of public relations and jour-

nalism, having been a teacher, publisher, author and publicity manager. He has owned and published community newspapers in the West and in Virginia, and for a time was executive secretary of the Racine, Wis., Chamber of Commerce. His book, "Community Journalim" is widely known and used as a textbook for journalism students. His talks will stress the public image of the physician.

Arthur M. Mickler, D.M.D., M.S., Louisville, will be the 1964 exchange speaker from the Kentucky Dental Association, and will present his address, "Baby Teeth are For Real" at the Wednesday morning general session of the annual meeting. Doctor Mickler, who graduated from the University of Louisville School of Dentistry in 1949, received his graduate training at the University of Michigan. He has served as an instructor of pedodontics at the U. of L. dental school.



Doctor Mickler

Among his professional affiliations are memberships in the American Dental Association, the American Society of Dentistry for Children, and the American Academy of Pedodontics. He was certified as a diplomate of the American Board of Pedodontics in 1956 and is a former chief of the dental staff of Louisville's Jewish Hospital.

KEMPAC Second Seminar Set As Annual Meeting Event

A meeting of political minds will take place this fall at the second annual KEMPAC Political Seminar and banquet to be held Monday, September 28 at Louisville in conjunction with the KSMA Annual Meeting, according to Hoyt D. Gardner, M.D., Louisville, chairman of the KEMPAC Board of Directors.

An important program underlining the increasing necessity of an active role for medicine in politics has been planned by KEMPAC (the Kentucky Educational Medical Political Action Committee) for the seminar and dinner set to begin at 4 p.m. in the Mirror Room of the Kentucky Hotel.

Donald E. Wood, M.D., chairman of the American Medical Political Action Committee, will be among the featured speakers for the sessions. Also on the program will be the governors of three states, candidates for political offices in Kentucky, and a number of other political leaders.

Following the afternoon session, a social hour is planned for 6 p.m., and the banquet at 7 p.m. Cost of tickets for the event is $6.00. Advance requests for tickets should be addressed to The Kentucky Educational Medical Political Action Committee, P.O. Box 5083 Cherokee Station, Louisville, Kentucky 40205.

Texas Humorist to be Speaker At President's Luncheon

"So—You Have a Problem?" is the intriguing title of the address to be given by Charles W. Jarvis, D.D.S., San Marcos, Texas humorist and philosopher, at the President's Luncheon September 30 during the KSMA Annual Meeting.



George P. Archer, M.D., Prestonsburg, KSMA president, who recently released information on the luncheon program, called Doctor Jarvis "a widely-known public speaker whose amusing approach to the problems of every-day life promise to give us one of the most informative and entertaining luncheon programs in many years."

Doctor Jarvis, a member of the American Medical Association's Speakers Bureau, is engaged in the private practice of dentistry at San Marcos. He is a native Texan who attended Texas A & M and the University of Houston before graduating from the United States Naval Academy at Annapolis, Maryland.

In addition to his D.D.S. degree, awarded by the University of Texas School of Dentistry, he holds a bachelor's degree in engineering. An elder in the First Christian Church of San Marcos, he is a past president of the Kiwanis Club in that city.

Doctor Jarvis, whose popularity as a speaker is attested by the 141 speaking engagements he held last year, was a carrier pilot in the U.S. Navy for three years and a veteran of World War II. He is a member of the Texas and American Dental Associations and a number of other dental groups.

Registration Deadline Sept. 5

September 5 is the last day to register to vote in Kentucky in the November elections, according to John C. Quertermous, M.D., Murray, chairman of the KSMA Council on Legislative Activities for National Affairs.

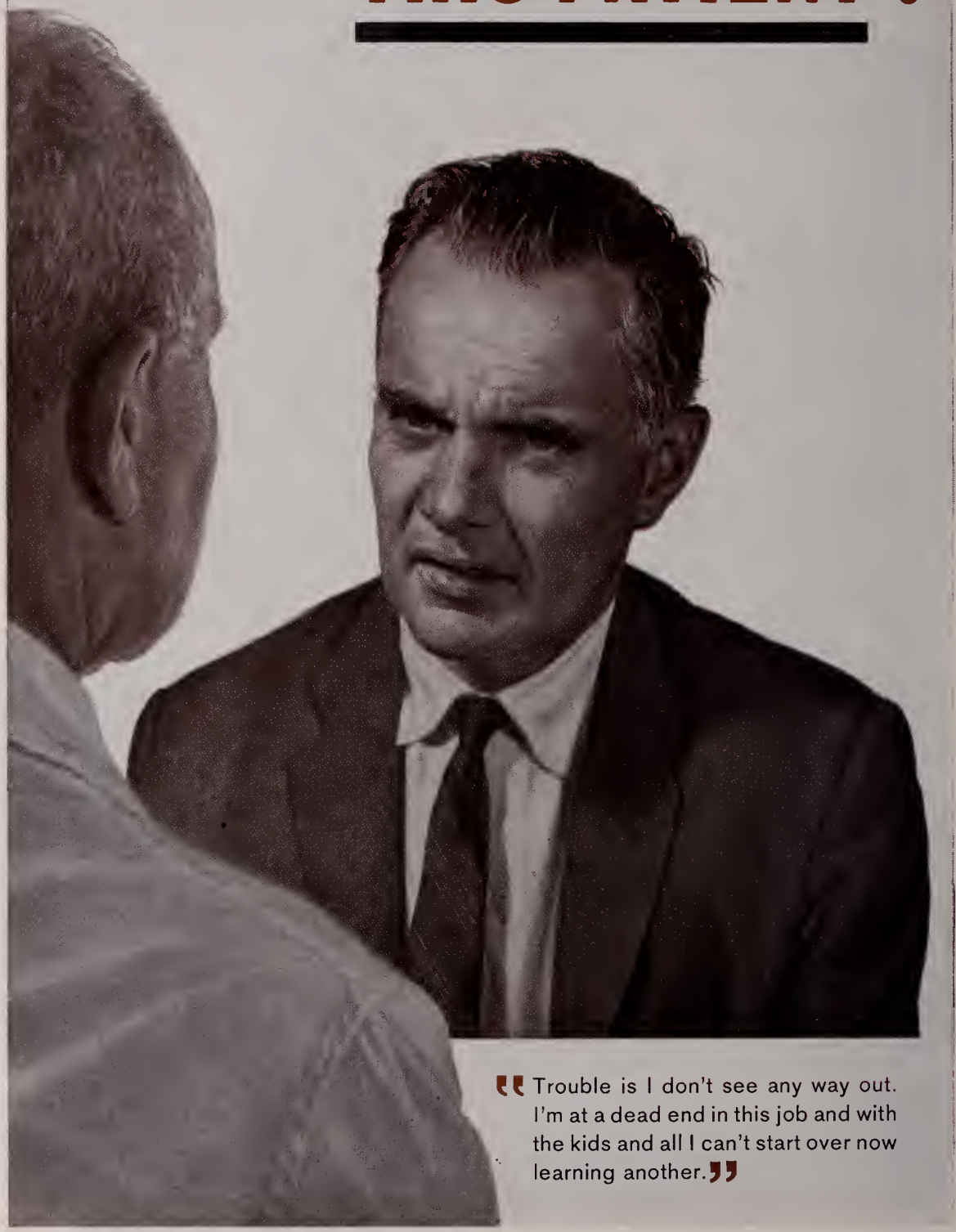
"In this highly important election year," Doctor Quertermous said, "it is vital that every physician in Kentucky cast his vote for the candidate of his choice." If your registration has lapsed or is not properly recorded, be sure to attend to this before September 5.

AMA Auxiliary Elects Mrs. Roles

Mrs. Nancy E. Roles, Prospect, was re-elected to the regional vice-presidency of the Woman's Auxiliary to the American Medical Association at the June 25 session of the AMA's Annual Meeting in San Francisco.

Mrs. Roles, the wife of Louisville surgeon Earl W. Roles, M.D., is a past president of the KSMA Auxiliary and is co-editor of the Auxiliary's *Blue Grass News*.

RECOGNIZE THIS PATIENT?



"Trouble is I don't see any way out. I'm at a dead end in this job and with the kids and all I can't start over now learning another."

When you recognize depression and anxiety traceable to an emotionally charged situation with no somatic disorder

—*start the patient on 'Deprol'*

Typical situations in which 'Deprol' is indicated:

marital or other family problems ■ death of a loved one ■ financial worries ■ fear of cancer, heart disease or other life-threatening illness ■ pre- and post-operative apprehensions ■ retirement problems, and many other stressful situations which cause the patient to feel a sense of loss, guilt or unworthiness

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' restores normal sleep, relaxes physical tensions, and improves appetite.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is relatively nontoxic and free of side effects.
5. When depression and anxiety accompany physical illness, 'Deprol' is compatible with drugs used to treat these organic conditions.

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

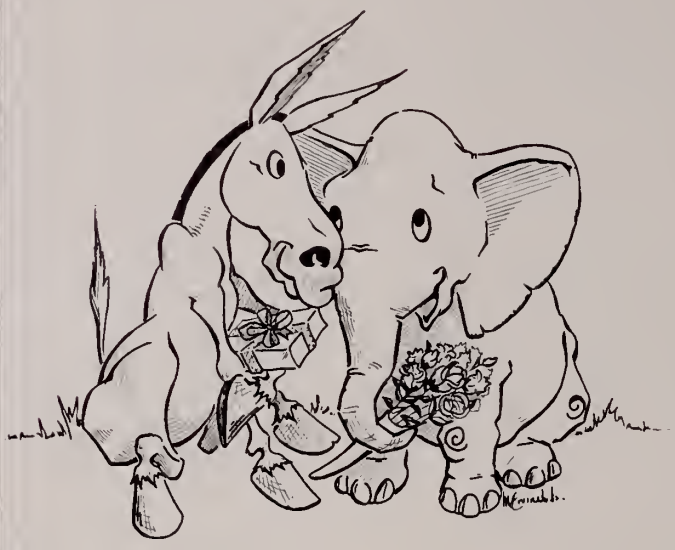
Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 tablet t.i.d. or q.i.d. May be increased gradually, as needed, to 6 tablets daily. With establishment of relief, may be gradually reduced to maintenance levels. **Supplied:** Light-pink, scored tablets Bottles of 50.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-1983

We're Getting Together



To Talk About

Politics

at the

Second Annual

KEMPAC Political Seminar

Please Join Us

Monday, September 28, 1964—Mirror Room, Kentucky Hotel

(First Day of the Kentucky State Medical Association Annual Meeting)

FEATURING: Nationally-Known Speakers—
Congressional Candidates for Kentucky Office—
AMPAC Chairman, Dr. Donald Wood—
And Many Other Leaders

Begins . . . . . 4:00 p.m.
Social Hour . . . . . 6:00 p.m.
Banquet . . . . . 7:00 p.m.

TICKETS : $6.00

For Advance Tickets, write:

KENTUCKY EDUCATIONAL MEDICAL POLITICAL ACTION COMMITTEE
KEMPAC
3532 Jonet — Louisville, Ky. 40205

W. K. Young Named New Director Of KSMA Field Services

W. Kenneth Young, Louisville, has been named new director of Field Services for the Kentucky State Medical Association, effective August 1, according to an announcement by J. P. Sanford, KSMA executive secretary.



Mr. Young

Mr. Young took over the post left vacant by the resignation of Bobbie R. Grogan, who returned to work with the State Department of Vocational Education.

Prior to accepting his position with KSMA, Mr. Young was assistant manager of the Kentucky Articicial Breeding Association with offices in Louisville. He served with that organization for 14 years, and had previosuly worked for two years for what is now the Kyana Milk Producers Association.

A native of Washington County, Mr. Young moved to Jefferson County as a youth and attended Anchorage High School. He received his B.S. degree in Agriculture from the University of Kentucky in 1948 following the interruption of his education by service in the U. S. Coast Guard in World War II.

A vestryman at St. Luke's Episcopal Church in Anchorage, Mr. Young is married to the former Elizabeth Bazzell of St. Mathews and the father of two children, Ken, Jr., 16, and Paula, 14. The Youngs make their home in Middletown.

Annual Meeting Phone is 584-2201 For Your Emergency Calls

Leave this number—584-2201 (Area code 502)—with your home, office and hospital if you wish to be reached while you are attending the KSMA Annual Meeting in Louisville September 29, 30, and October 1. A message center, answering this telephone number, will be located in the center of the Technical Exhibit Hall at the Convention Center.

It is requested that all physicians planning to attend the Annual Meeting leave this number with appropriate persons so that they may be contacted. Due to the difficulty in locating individual physicians at a given time, messages will only be posted at the message center. You are urged to check at the center for your calls.

The booth, sponsored by the Southern Bell Telephone Company and manned by Bell employees, is being used by KSMA for the first time this year in order to create and maintain a more effective message system.



Doctor Ward



Doctor Welch

Dr. Ward to Head AMA in '65-'66; Dr. Welch is New President

Donovan F. Ward, M.D., Dubuque, Iowa, vice-president of the American Medical Association for the 1963-64 year, was chosen president-elect of the AMA at its 1964 annual meeting in San Francisco in June.

Norman A. Welch, M.D., Boston internist and a long-time foe of socialized medicine, was installed as 1964-65 president of the AMA on June 23. Milford O. Rouse, M.D., Dallas, was re-elected speaker of the House of Delegates, and C. Bornemeier, M.D., Chicago, vice-speaker.

Doctor Welch, who took over the presidency from Edward R. Annis, M.D., Miami, was for four years speaker of the AMA House of Delegates and has been active in Blue Shield Plans at both state and national levels. He is a graduate of Harvard Medical School.

Doctor Ward, a former AMA delegate from the Iowa Medical Society, has practiced surgery in Dubuque since 1931 with the exception of four years since in the U.S. Navy in World War II. He has been active in the affairs of organized medicine in Iowa, and in civic and fraternal organizations. A graduate of the University of Iowa College of Medicine, he is a Fellow of the American College of Surgeons and the International College of Surgeons.

Dr. Archer, Other Presidents Honored at AMA Session

KSMA President George P. Archer, M.D., Prestonsburg, along with the presidents of other state and territorial medical associations and a number of special AMA guests from national organizations, was recognized and honored at the special Sunday opening session of the AMA Annual Meeting in San Francisco June 21.

For the first time the House of Delegates met on Sunday, at which time the featured speaker was Edward R. Annis, M.D., Miami, outgoing AMA president.

Doctor Annis told the attending group that a greater effort is needed in the areas of continuing medical education and health education programs. He also urged state and county medical associations to bolster their paid executive personnel to help carry out local, state and national projects.

Dr. Long Re-Elected to AMA Board of Trustees Post

Robert C. Long, M.D., Louisville, was re-elected by acclamation to a seat on the Board of Trustees of the American Medical Association during the AMA's annual convention in San Francisco June 21-25. He was elected for the first time in 1963 to fill a one year unexpired term.



Doctor Long

Doctor Long's name was placed in nomination by KSMA Senior Delegate Wyatt Norvell, M.D., New Castle.

Following numerous seconding speeches by delegates of various states, the motion that he be elected by acclamation was offered by Carroll Witten, M.D., Louisville, delegate to the AMA from the Section on General Practice.

Alvin J. Ingram, M.D., Memphis, was elected to a three year term on the Board of Trustees, replacing R. B. Robins of Camden, Ark.

Kentucky Well Represented At AMA Annual Meeting

Wyatt Norvell, M.D., senior delegate from New Castle, led the Kentucky delegation, including delegates J. Thomas Giannini, M.D., Louisville, and John C. Quertermous, M.D., Murray, at the 113th annual meeting of the American Medical Association last month in San Francisco.



Doctor Norvell

George P. Archer, M.D., KSMA president, and Mrs. J. Murray Kinsman, M.D., Louisville, Woman's Auxiliary president, attended their respective meetings during the AMA convention. Doctor Giannini was selected this year to serve on the AMA Reference Committee on legislation and Public Relations.

Kentucky's three alternate delegates, with Dean Donn L. Smith of U. of L. and Dean William R. Willard of U. of K., and a number of other KSMA members, were seen attending the meetings of the House of Delegates. Alternates are Charles G. Bryant, M.D., Louisville, William W. Hall, M.D., Owensboro, and Charles C. Rutledge, M.D., Hazard.

Doctor Norvell, the senior delegate, expressed his appreciation for the cooperation of the delegates for accepting and discharging their responsibilities so effectively both in reference committee assignments and the hospitality suite.

Flying Physicians to Meet

The tenth annual meeting of the Flying Physicians Association will be held at the Riviera Hotel, Palm Springs, Calif., from September 27 through October 2, according to James H. Callis, M.D., Owensboro, the association's Kentucky State Chairman.

Make Hotel Reservations Now For KSMA Annual Meeting

For those who have not made hotel arrangements for the Annual Meeting of the Kentucky State Medical Association at Louisville in September, KSMA President George P. Archer, M.D., Prestonsburg, urges that this be done as soon as possible.

Excellent accommodations are available in hotels and motels in the downtown area or within easy access of the facilities to be used for our annual meeting. So that you may be sure of rooms, you are urged to make your reservation soon.

KSMA Adds 13 Physicians To Membership Roster

Thirteen Kentucky physicians have become new members of the Kentucky State Medical Association as of July 15. The records at this time show a total membership of 2,121, a marked increase over membership by July of the past several years.

Recently announced new members from Lexington include: William E. Bakewell, M.D., E. P. Jenevein, Jr., M.D., Karl S. Klicka, M.D., and Tom F. Whayne, M.D. Dannon N. Huggins, M.D., Providence, is also a new member.

Louisville physicians newly listed at this time are Alan M. Bornstein, M.D., E. Dean Canan, M.D., Paul C. Grider, Jr., M.D., and John E. Kuhn, M.D.

Also listed among the new members are George C. Barber, M.D. and F. P. Fornaris, M.D., both of Glasgow; John A. Ritter, M.D., Harlan; and Keith Linville, M.D., Central City.

U.L. Alumni Gather at AMA

Approximately 100 alumni of the University of Louisville School of Medicine, their wives and guests, attended the U. of L. Medical Alumni dinner meeting at the Fairmont Hotel in San Francisco June 23 during the annual meeting of the AMA.

The meeting was arranged by Harry R. Walker, M.D., a U. of L. alumnus and orthopaedic surgeon now practicing in San Francisco. The Fairmont served as the Headquarters Hotel for the AMA meeting.

County Society Reports

Mason

Robert M. Blake, M.D., Maysville, was elected last month to the office of president of the Mason County Medical Society, and John Teegan, M.D., Maysville, was named secretary-treasurer.

Harry C. Denham, M.D. will be delegate to KSMA this year, and Williams H. Cartmell, M.D., will serve as alternate. Both are from Maysville.



one of the fundamental drugs in medicine

Smith Kline & French Laboratories

SK&F



Big Spring Country Club, on Dutchman's Lane near the KSMA Headquarters Office, will be the site this year of the annual Kentucky State Medical Golf Association Tournament to be held September 28 in conjunction with the KSMA Annual Meeting. Participants' applications should be returned to KSMA Headquarters by September 1. (See Form Below.)

Big Spring Club Will Host 1964 KSMA Golf Tournament

Big Spring Country Club, located on Dutchmans Lane near the KSMA Headquarters Building in Louisville, has been chosen at the site of the 1964 Annual KSMGA Golf Tournament on Monday, September 28.

Kenton D. Leatherman, M. D., Louisville, chairman of the KSMA Golf Committee, has announced that the tournament has been completely revised for this year and should be much more appealing to the participants.

The 1964 Tournament will be a one-day affair only. All participants will tee off between the hours of 10:00 a.m. and 1:00 p.m. on Monday, September 28. Big Spring Country Club will be open on that date only to those entering the KSMGA Golf Tournament providing an enjoyable day of fellowship and recreation to the doctor golfers.

So that appropriate arrangements can be made at the club for meals, beverages, etc., the committee has set a registration deadline of September 1. All doctors desiring to play in this year's tournament must submit their annual dues and application form by midnight Tuesday, September 1.

The $7 dues payable to the Kentucky State Medical Golf Association includes your green fees. Permanent trophies will be awarded to the low net and low gross winners in the Championship Division and the Senior Division (over 50 years of age.) A number of additional prizes will also be presented to others scoring well in the Tournament.

Participants need not submit handicaps. The Bankers Handicap System will be used which gives a high handicap golfer the same opportunity of being a winner as the low handicap golfer.

APPLICATION FOR MEMBERSHIP

KSMA Golf Association

Please complete and return immediately to: KSMA Golf Committee
Kentucky State Medical Association
3532 Janet Avenue, Louisville, Kentucky 40205

Name .....

Address ..... (Town) .....

Amount enclosed:..... $7 (Regular playing member) ..... $3 (non-playing member)

...$3 (I am a member of Big Spring Country Club) Others I would like to play with are: .....

..... I would like to tee off at the following time.....

TOURNAMENT WILL BE HELD MONDAY, SEPTEMBER 28.

why does 150 mg.



do more than 250 mg.



of other tetracyclines?

Because it has up to 3½ times the *in vitro* antibacterial activity[1]...combined with lower rate of decay in serum, slower renal clearance...a favorable depot effect, resulting from protein binding...all providing rapid, higher and sustained *in vivo* activity with as much as 2 days' extra activity.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. **Side Effects** typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative *in vitro* Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

7516-3

AMA House of Delegates Takes Stand on Tobacco and Human Rights Issues at 113th Annual Convention in San Francisco

Tobacco and health, human rights, physician-hospital relations, continuing medical education, the cost of medical care, and federal subsidization of prepayment plans and health insurance companies were among the major subjects acted upon by the House of Delegates at the American Medical Association's 113th Annual convention held June 21-25 in San Francisco.

The House approved a strong stand on tobacco and health by calling cigarette smoking "a serious health hazard". This action was taken after the reference committee on Public Health and Occupational Health considered ten resolutions and a Board of Trustees report on the subject and heard considerable testimony.

In adopting a four-point reference committee report, the House said, "the American Medical Asssociation is on record and does recognize a significant relationship between cigarette smoking and the incidence of lung cancer and certain other diseases."

Sets Up Research Program

It urged that programs be developed to disseminate vital health education material on the hazards of smoking, and recognized the contributions of the Surgeon General's Committee in its comprehensive report.

Finally, the House said that the delegates and the Board of Trustees "should take great pride in the establishment of the research program on tobacco and health that is being carried out by the AMA Education and Research Foundation."

In adopting the report of the AMA-ERF, the House called attention to the following statement:

"The Board of Directors of AMA-ERF and the Board of Trustees of the AMA were clearly aware of the possibility of criticism in accepting this grant (10 million dollars from several tobacco companies). But against that possibility they weighed the potential benefits to the public who will continue to smoke and conclude that the risk was insignificant by comparison. The only hope of minimizing the hazards of smoking lies in research which points to the course that the AMA as well as others must take."

Human Rights

On the major issue of human rights the House declared itself "unalterably opposed to the denial of membership, privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, ethnic affiliation, or national origin."

In addition, the House called "upon all state medical associations, all component societies, and all individual members of the AMA to exert every effort to end every instance in which such equal rights, privileges and responsibilities are denied."

Conclusions and recommendations in a significant and extensive report on physician-hospital relations were adopted by the House. Prepared by the Council on Medical Service's Committee on Medical Facilities, the report stresses "the imperative need for the medical profession to assume responsibility for the quality, continuity, and availability of professional services and for the coordination of these services with the other essential supportive aspects of health care."

The report's recommendations are designed to serve as guidelines for physicians in meeting the problems involved in the changing patterns of care, such as: appointment of salaried chiefs of staff; appointment of salaried heads of clinical departments; appointment of salaried directors of medical education; employment of salaried physicians for out-patient and emergency departments; use of salaried physicians to provide care ordinarily provided by interns and residents; and utilization of closed-panel prepayment medical care programs by hospitals.

Continuing Medical Education

Authorization was made by the House to establish an AMA-sponsored survey and accreditation program in continuing medical education. In the program attention will be concentrated on institutions and organizations offering courses rather than on individual courses, and appraisal of an institution's or organization's program will be carried out only at its request.

Cost of Medical Care

A four-volume report of the AMA Commission on the Cost of Medical Care was received by the delegates, and the House concurred with the Board of Trustees that the conclusions and recommendations of the Commission will be studied and a report will be made to the House for its consideration of the 1964 Clinical Convention.

In its report the Board said that the Commission "is aware that its efforts will not result in a magic reduction in the price of medical and hospital services. It does believe, however, that its study has produced a considerable amount of new and relevant information which will serve as a basis for better understanding by the public and the medical profession of this complex subject". (A copy of this report is available in the KSMA Headquarters Office.)

Reaffirmed the AMA policy favoring federal grants for "bricks and mortar"—funds for construction and renovation of medical schools, hospitals, related institutions, and mental health centers—but urged that the "advantages and desirability of multiple source financing be kept clearly in mind." The House also was informed by the Board that it is appointing a commission to conduct a broad study of the role of federal support of medical research.

The House went on record as opposing federal subsidization of prepayment plans and health insurance companies, and it asked for an AMA study of the development of state programs which utilize prepayment plans or health insurance companies in the implementation of state programs of medical aid to the aging under the Kerr-Mills law.

—A proposal to poll all AMA members concerning compulsory Social Security for self-employed physicians was rejected by the House. In addition, the House concurred with the reference committee in opposing polls of the membership on issues of "great or even moderate importance" because the House members express the majority sentiments of the constituents on all questions coming before the House.

—A three-point communications program designed to improve the public relations position of the medical profession was endorsed by the House on recommendation of the AMA Committee on Communications. The program includes a redoubling of efforts by county and state societies, closer liaison with media personnel and prompt information to state societies on AMA news releases and testimony.

Miscellaneous Actions

Approved a comprehensive inquiry of the causative factors for the sharp increase in syphilis and gonorrhea and urged the AMA to "take leadership in educational and research measures designed to control and eliminate syphilis."

Okayed a national conference on areawide planning of hospitals and related health facilities, to be sponsored under the auspices of the AMA.

Agreed to continue and broaden studies on the problems of unwed mothers, illegitimacy and other related matters and to develop positive preventative programs.

Asked the Board of Trustees to investigate establishment of a wire communications system between AMA headquarters in Chicago and offices of state medical associations.

Agreed with the Board that a forum for representatives of national medical specialty societies and the American Academy of General Practice be held on November 1, 1964, in Chicago.

Recommended that the Board of Trustees use the talents of Edward R. Annis, M.D., immediate past president, and other qualified spokesmen for medicine with appropriate remuneration.

Asked the Committee on Insurance and Prepayment Plans of the Council on Medical Service to consider a revision of simplified health insurance claims forms.

Recommended that the Board of Trustees approve the establishment of an ad hoc study on family practice as proposed by the Council on Medical Education.

In addition to Doctor Ward, the new president-elect, the following officers were named:

Carlton Wertz, M.D., Buffalo, vice-president; Milford O. Rouse, M.D., Dallas, speaker of the House; and Walter C. Bornemeier, M.D., of Chicago, vice-speaker.

Dr. Rainey Elected V-Pres. of National Jaycees



Fred C. Rainey, M.D., Elizabethtown, was elected a vice president of the National Junior Chamber of Commerce June 25 at the Annual Jaycees convention in Dallas.

Under Doctor Rainey's leadership as president of the Kentucky Jaycees for 1963-64, the state rose to 11th place in the 'Parade of States', a ranking based on such things as activities, membership, and new chapters.

A former KSMA District Legislative Key Man for the Fourth Congressional District, Doctor Rainey has also served as a member of the board of Trustees of KEMPAC. He is a 1955 graduate of the University of Tennessee College of Medicine.

Traffic Conference Held July 16 in Frankfort

Arthur H. Keeney, M.D., Louisville, chairman of the KSMA Highway Safety Committee, represented the association July 16 in a state-wide conference of traffic-case judges, county judges, prosecutors, and police chiefs aimed at reducing Kentucky's increasing traffic-death toll.

Approximately 250 people attended the Frankfort conference in the department of Health Auditorium; the largest number ever attending a meeting on this subject. The session was called at the request of Governor Edward T. Breathitt because of the alarming increase in deaths on Kentucky Highways in recent months.

Appearing on the panel with Doctor Keeney, were Judge John Palmore of the Appellate Court, Judge T. B. Birkhead, Owensboro, president of the County Judges Association, Chief Lewis Mutters, Ashland, president of the Kentucky Peace Officers' association, and R. C. Stephenson, Louisville, president of the Kentucky Bar Association.

MADISON, INDIANA—PSYCHIATRISTS AND GENERAL PHYSICIANS wanted in a fully accredited 1500-bed State Psychiatric Hospital, dynamically oriented, intensive and continued treatment programs. Salary Ranges, General Physicians $1200-$1475 per month. Psychiatric Physicians (3 years residency in Psychiatry or Neurology) $1400-$1675 per month. Psychiatrist (Board Eligible) $1500-$1775 per month. Psychiatrist (Board Certified) $1600-$1875 per month. Complete maintenance available for single or married applicants with families at a very reasonable rate. Apply to: Ott B. McAtee, M.D., Superintendent, Madison State Hospital, Madison, Indiana 47251

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

IN KENTUCKY

AUGUST

13	KAGP Seminar, Bardstown, Ky.
20	6th KSMA Trustee District Meeting, Glasgow Country Club & TB Hospital
29-30	Bluegrass Seminar, KAGP, Lexington, Ky.

SEPTEMBER

12	Internal Medicine, American College of Physicians, Joint Meeting of Kentucky and Tennessee, Louisville, Ky.
24-25	American College of Cardiology, Symposium on Operable Heart Disease, U.K. Medical Center, Lexington, Ky.
29-Oct. 1	KSMA ANNUAL MEETING, Convention Center, Louisville, Ky.

OCTOBER

8	KAGP Seminar, Maysville, Kentucky
26-27	American Association for Automotive Medicine, Stouffer's Inn, Louisville, Kentucky

SURROUNDING STATES

AUGUST

24-27	American Hospital Association, Palmer House, Chicago, Ill.
24-27	American Academy of Physical Medicine and Rehabilitation, Statler-Hilton, Boston, Mass.
25-28	American Association of Blood Banks, Washington, D.C.

SEPTEMBER

9-12	International College of Surgeons, Chicago, Ill.
10	10th Annual Medical Symposium, Cabell County Medical Society, Frederick Hotel, Huntington, W. Va.
10-12	American Association of Obstetricians and Gynecologists, Homestead, Hot Springs, Virginia
17-19	5th Annual Cancer Conference, American Cancer Society and National Cancer Institute, Philadelphia, Pa.
26-27	Congress on Occupational Health, AMA, Rice Hotel, Houston, Tex.

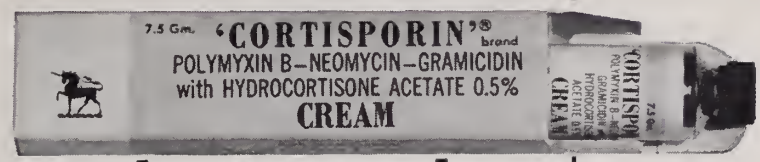
OCTOBER

5-9	American College of Surgeons, Conrad Hilton Hotel, Chicago, Ill.
5-9	American Association of Public Health Physicians, New York Hilton, New York, New York
8-10	American College of Physicians, Hotel Biltmore, Los Angeles, Calif.
10-14	American Society of Anesthesiologists, Bal Harbour, Florida
17-20	College of American Pathologists, Americana Hotel, Bal Harbour, Fla.
18-21	American College of Gastroenterology, Roosevelt Hotel, New York, N.Y.
18-23	American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Ill.
23-24	American Heart Association, Chalfonte-Haddon Hall, Atlantic City, New Jersey
24	American Academy of Pediatrics, New York Hilton, New York, N.Y.
28-30	American Cancer Society, Biltmore Hotel, New York, New York

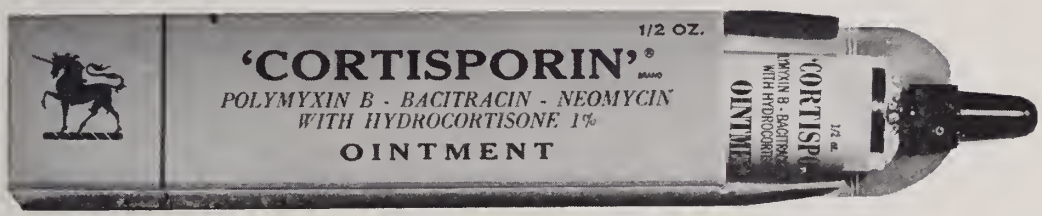
NOVEMBER

7-8	National Conference on Disaster Medical Care, LaSalle Hotel, Chicago
9-12	Interstate Postgraduate Medical Association of North America, Pittsburgh, Pennsylvania
16-19	Southern Medical Association, Memphis, Tennessee
20-21	American Psychiatric Association, Bellevue Stratford Hotel, Philadelphia, Pennsylvania
28-29	American College of Chest Physicians, Interim Meeting, Miami Beach, Florida
29	National Conference on Medical Aspects of Sports, AMA, Miami Beach, Fla.
29-Dec. 2	AMA Clinical Meeting, Miami Beach, Florida

CHOOSE THE PRODUCT TO FIT THE NEED



a new vanishing cream base



a special low melting point base

anti-inflammatory
bactericidal
antipruritic
rarely sensitizing

CREAM—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) 5.0 mg.; Gramicidin 0.25 mg.; Hydrocortisone Acetate 5.0 mg. (0.5%).

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, distilled water, and 0.25% methylparaben as preservative.

Available: In tubes of 7.5 Grams.

OINTMENT—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Hydrocortisone 10 mg. (1%).

In a special white petrolatum base.

Available: In tubes of ½ oz. and ⅛ oz.

*U.S. Patent Nos. 2,565,057–2,695,261

Indications: Wherever inflammation or infection occurs and is accessible for topical therapy.

Contraindications: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

Caution: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

87 Kentucky M.D.s Register at AMA Annual Meeting;

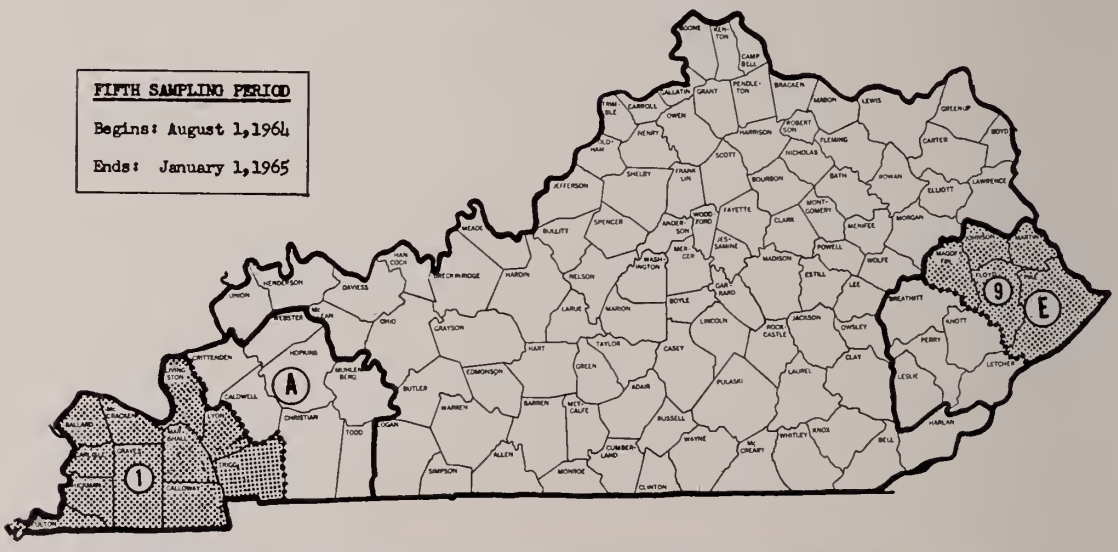
Total Registration Figures Reach 49,437

Eighty-seven Kentucky physicians registered for the 1964 annual meeting of the American Medical Association held this year in San Francisco, according to Lloyd W. Prang, director of the Physician Membership records section of the AMA.

Final registration figures for the 113th Annual Meeting reached a grand total of 49,437, including 14,229 physicians. A complete list of Kentucky physicians registered for the meeting follows:

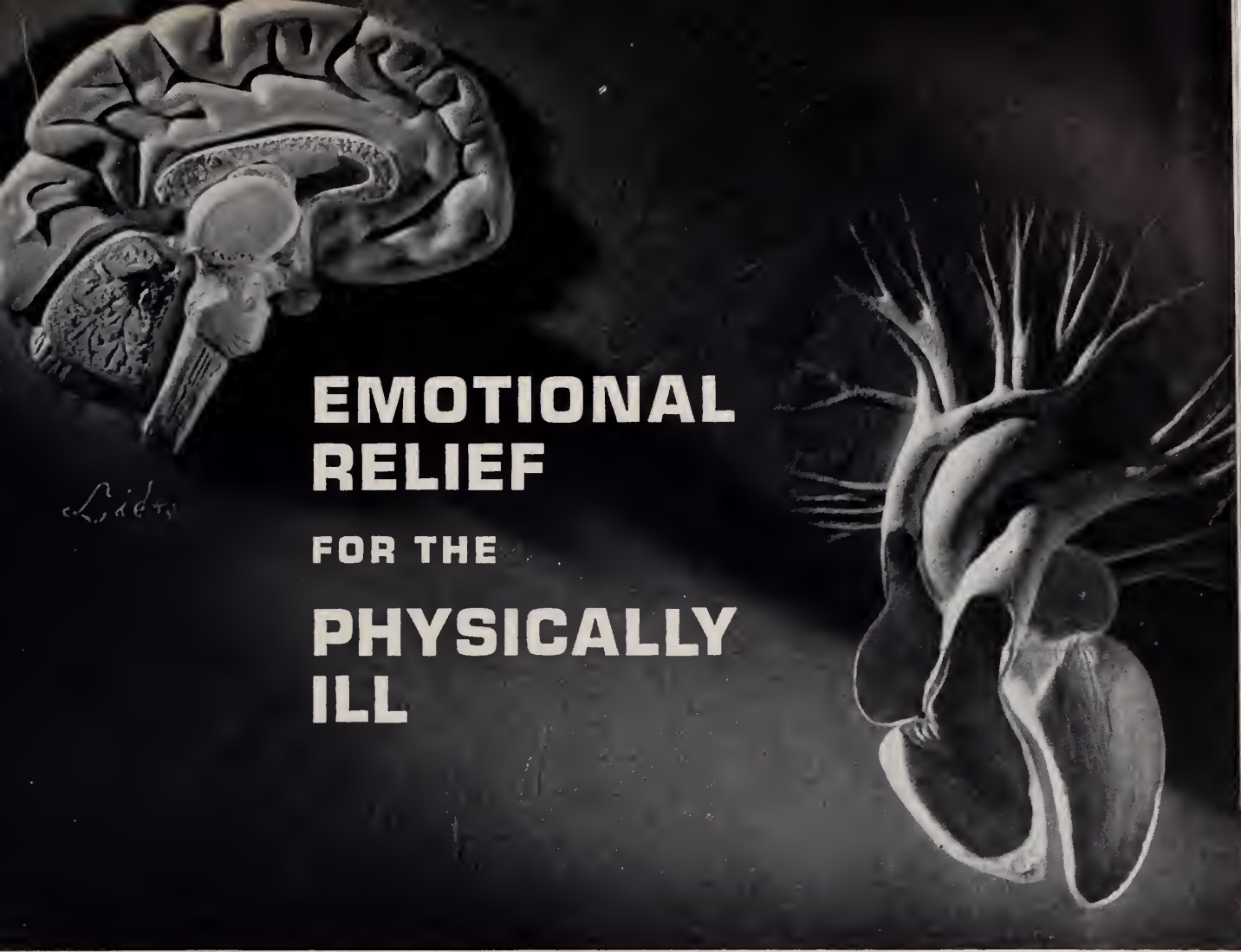
George P. Archer, M.D., Prestonburg
S. P. Auerbach, M.D., Louisville
Thomas E. Averitt, M.D., Winchester
Herbert E. Brizel, M.D., Louisville
George F. Brockman, M.D., Greenville
Duval Bushong, M.D., Owensboro
W. M. Buttermore, M.D., Corbin
Boyd Caudill, M.D., Lawrenceburg
Walter L. Cawood, M.D., Ashland
J. P. Chapin, M.D., Fort Thomas
Robert H. Cofield, M.D., Covington
Armand E. Cohen, M.D., Louisville
Carl Cooper, M.D., Bedford
Wilford L. Cooper, M.D., Lexington
M. R. Cronen, M.D., Louisville
Royce E. Dawson, M.D., Owensboro
Richard E. Doughty, M.D., Louisville
M. A. Douglass, Jr., M.D., Magnolia
Sattar Farzan, M.D., Louisville
Hoyt D. Gardner, M.D., Louisville
Ralph A. Gettelfinger, M.D., Louisville
J. Thomas Giannini, M.D., Louisville
Armond T. Gordon, M.D., Louisville
R. F. Greathouse, M.D., Louisville
Edward O. Guerrant, M.D., Winchester
Kooroch Haery, M.D., Louisville
Reza Haghighat, M.D., Louisville
William W. Hall, M.D., Owensboro
Joseph Hamburg, M.D., Lexington
E. Wylda Hammond, M.D., Lexington
James A. Harris, M.D., Paducah
Fred C. Hauck, M.D., Owensboro
C. H. Luhr, Jr., M.D., Louisville
John C. Hill, M.D., Louisville
Thomas S. Hutsell, M.D., Louisville
James B. Hyman, M.D., Louisville
V. A. Jackson, M.D., Clinton
William Joule, M.D., Louisville
Astra A. Kidd, M.D., Brownsville
Bobby Jack Kidd, M.D., Brownsville
George Kimbrough, M.D., Louisville
Laura Kimbrough, M.D., Louisville
J. Murray Kinsman, M.D., Louisville
Robert C. Long, M.D., Louisville
Paul F. Maddox, M.D., Campton
Shelton H. Mann, M.D., Louisville
J. Jack Martin, M.D., Tompkinsville
Thos. R. Marshall, M.D., Louisville
Homer B. Martin, M.D., Louisville
Lloyd Mayer, M.D., Lexington
Geo. C. McClain, M.D., Benton
Carolyn H. McKinley, M.D., Glasgow
Geo. G. McKinley, M.D., Glasgow
Beverly T. Mead, M.D., Lexington
J. F. Minnis, Jr., M.D., Louisville
Chas. S. Mooney, M.D., Lexington
Arthur J. Nash, M.D., Jenkins
T. L. Nelson, M.D., Lexington
David H. Neustadt, M.D., Louisville
Wyatt Norvell, M.D., New Castle
John S. Oldham, M.D., Owensboro
William J. Oldham, M.D., Owensboro
Earl P. Oliver, M.D., Scottsville
Lee Palmer, M.D., Louisville
E. D. Pellegrino, M.D., Lexington
John C. Quertermous, M.D., Murray
B. F. Radmacher, M.D., Louisville
Gilbert G. Rawlings, M.D., Louisville
Edward H. Ray, M.D., Lexington
Ben A. Reid, M.D., Louisville
James S. Rich, M.D., Lexington
Earl W. Roles, M.D., Louisville
Charles C. Rutledge, M.D., Hazard
James B. Sears, M.D., Lexington
Kenneth L. Sears, M.D., Lexington
S. A. Shaffer, M.D., Ashland
Jerry M. Shaw, M.D., Louisville
Donn L. Smith, M.D., Louisville
George C. Stege, M.D., Louisville
Daniel Stowens, M.D., Louisville
Lewis R. Sutton, M.D., Elkton
Larry R. Tackett, M.D., Louisville
Beverly T. Towery, M.D., Louisville
Herbert Wald, M.D., Louisville
William V. Wash, M.D., Lexington
Thomas R. Wabon, M.D., Louisville
William R. Willard, M.D., Lexington

KENTUCKY - CORNELL AUTOMOTIVE CRASH INJURY RESEARCH



Area Subject to ACIR study of injury-producing passenger car accidents.

August 1, 1964 marked the beginning of the third and final year for the Kentucky-Cornell Automotive Crash Injury Research program, a continuing project being carried on in cooperation with KSMA, the State Department of Health, Kentucky Hospital Association, and the State Police. The dark areas on the map are those from which automobile injury samples will be taken during the six-month sampling period from August 1, 1965.



RELIEVES ANXIETY, APPREHENSION AND TENSION...



All day long

. . . keeps the patient calm, and the mind clear.



All night too

. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400

(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CME-760

WALLACE LABORATORIES *Cranbury, N. J.*

A.R.H.I. Completes Purchase of Remaining U.M.W. Hospitals

The last five hospitals of the United Mine Workers' chain of ten medical facilities in Eastern Kentucky, West Virginia, and Virginia were sold on June 30 to Appalacian Regional Hospitals, Incorporated, the organization which bought the first five hospitals last year.

Last month's transactions included the sales of U.M.W. hospitals located at Pikeville and South Williamson, Ky., Beckley and Man, W. Va., and Wise, Va. The five have a total bed-capacity of 554.

All of the hospitals included in the purchase will be operated by the A.R.H.I., an organization set up with the help of the United Presbyterian Church's Board of National Missions, with a loan from the Area Redevelopment Administration of the U.S. Department of Health, Education and Welfare.

Medical School News

Heart Research and Treatment Studies Receive Grants

Grants in the amount of $86,475 have been granted by the Kentucky and Louisville Heart Associations to continue research and treatment of heart disease. Eight are new grants and the remainder provide continuing support for current programs, according to William R. Bushong, M.D., Tompkinsville, KHA president, and Jack L. Chumley, M.D., Louisville, president of the Louisville and Jefferson County Heart Association.

Two projects are jointly supported by the groups. One grant of $18,000 went to continuation of heart research at the University of Louisville by Joseph P. Holt, M.D., and another of $7,000 to the cardiovascular laboratory at Louisville General Hospital, directed by Leonard Leight, M.D.

Projects at two Medical Schools Get Funds

KHA grants presented to both U. of K. and U. of L. researchers are:

Continuation of heart research at U.K., William Waugh, M.D., $16,000. Student summer research scholarships at U.K., $6,000; and partial support for September Heart Symposium at U.K., Borys Surawicz, M.D., $1,500.

Margaret Vermillion, M.D., received $5,850 for support of heart clinics at Louisville Childrens Hospital and elsewhere. Grants for other technical studies went to Breen Ratterman, M.D., for $1,800, and to John J. McHugh, $300, both at U. of L.

The Heart Association of Louisville and Jefferson County announced the following grants:

Student summer research scholarships at U. of L., $9,000; partial support of equipment for the cardiovascular laboratory at Childrens Hospital, Kareen Minhas, M.D., $3,000; Children's Hospital Heart Clinic, $5,450; and development of techniques for open-heart surgery in children, Allan M. Lansing, M.D., U. of L., $2,600.

Dr. Allen is Sportsman of Year

Claude L. Allen, M.D., Martin, was named Kentucky Sportsman of the Year at the annual meeting of the League of Kentucky Sportsmen at Ashland in June. Doctor Allen, a general practitioner, has been vice-president of the League and a leader in conservation in Eastern Kentucky.

To Serve on SMJAB Board

The stock holders of the State Medical Journal Advertising Bureau elected the managing editor of The Journal of KSMA, J. P. Sanford, as a member of its Board of Directors during the AMA meeting in San Francisco. The by-laws provide that one of the five directors may be a layman, the remainder must be physicians.

Heart Symposium Set for U. K.

"Operable Heart Disease" will be the topic of the American College of Cardiology workshop to be held at the University of Kentucky Medical Center September 24-25. The program is designed to review the recent advances in diagnosis and treatment of the disease. Information may be obtained by writing to Borys Surawicz, M.D., chief of the cardiovascular section at U.K., director of the workshop.

The Modern Physician



must spend many hours keeping himself informed so that he may better serve his patients and his profession. Today, a doctor refers cases requiring special techniques to those trained in handling them.

Just so, select your jeweler who must have training, experience and an established reputation for honesty and dependability. KENDRICK is such a jeweler, being a REGISTERED JEWELER of the AMERICAN GEM SOCIETY. Call on us at any time for expert advice and assistance in selecting quality gems. This service costs no more.

Kendrick
Jewelers since 1832
MEMBER AMERICAN GEM SOCIETY
619 SO. FOURTH ST. 584-5232

The case of diaper rash



solved by NEW UNDERCOVER AGENT

BAKER'S **CREME**

DIAPER-SIL™



CONTAINS : panthenol, benzalkonium chloride, dimethylpolysiloxane, in a water-miscible cream base.

eliminates ammonia-splitting bacteria. The bactericidal component, benzalkonium chloride, has a proven record of effectiveness. It acts rapidly against a wide range of organisms implicated in diaper rash — including Brevibacterium ammoniagenes and Alcaligenes faecalis.

soothing, healing, protective. DIAPER-SIL also provides panthenol in a special base containing silicone . . . helps to soothe inflamed skin, protect from external irritants and gently promote healing.

TO HELP PREVENT AND TREAT DIAPER RASH, CHAFING AND SIMILAR CONDITIONS

BAKER LABORATORIES, INC. Cleveland, Ohio 44115

Subsidiary of U. S. Vitamin & Pharmaceutical Corp.


just
turned
hypertensive



a 15 mm. Hg. drop in diastolic pressure would also suit her very well

for suitably gradual, physiologic hypotensive treatment

HYDROMOX®

QUINETHAZONE·TABLETS

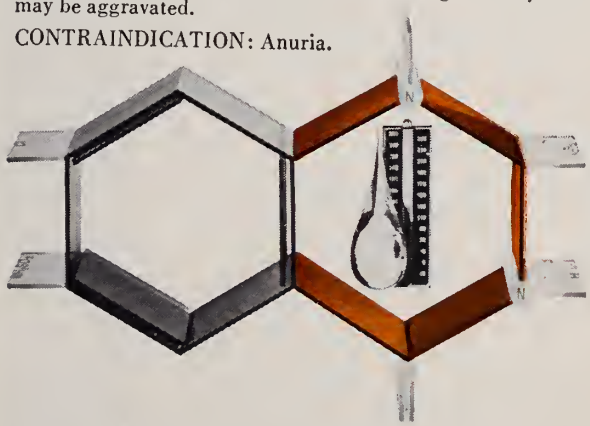
antihypertensive diuretic

HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg.,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.



1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

Lederle

LEDERLE LABORATORIES,
A Division of AMERICAN CYANAMID COMPANY,
Pearl River, New York

8276-4

News Items

Charles Noss, M.D. has announced the opening of his office at Stanton, where his practice will be limited to general medicine. Doctor Noss, a native of New York, is a graduate of the University of Louisville School of Medicine in 1963 and interned at St. Elizabeth Hospital in Dayton, O.

Glen D. Richards, M.D. has started general practice at Lewisport, following the completion of his internship at St. Elizabeth Hospital in Dayton, O. Doctor Richards, who is a native of Hancock County, graduated from the University of Louisville School of Medicine in 1963.

Ardy C. Wright, M.D., is now associated with **Thornton Bryan, Jr., M.D.** at Cadiz, where he will have a general practice. Doctor Wright, who graduated from the University of Louisville School of Medicine in 1962, interned and completed one year of residency at Columbus, Ga.

James F. Rold, M.D., will practice general medicine at Hardinsburg in association with **James G. Sills, M.D.** Doctor Rold is a 1963 graduate of the University of Louisville School of Medicine and interned at Lakeland General Hospital at Lakeland, Fla.

KSMA Council and Committee Reports

Council on Medical Services

W. Vincent Pierce, M.D., Covington, Chairman

Louisville **July 2, 1964**

The Council on Medical Services has held its second meeting of this Associational Year and plans to meet once more in the near future.

At the request of the Board of Trustees, the Council discussed at some length the various health care programs planned or being conducted in our state that are government sponsored and are related to "Appalachia". The next meeting of the Council will be to discuss these programs in more depth.

The Council members also reviewed the final reports of the Committees serving under the Council and have forwarded these to the Board of Trustees with the Council's recommendations.

Council on Allied Professions And Related Groups

W. Donald Janney, M.D., Covington, Chairman

KSMA Headquarters **June 9, 1964**

The Council on Allied Professions and Related Groups recently met to consider the final reports of the committees serving under the Council and the duties of each of the committees. Members of the Council approved a statement of the duties of the Council's committees and forwarded this information to the Board of Trustees for consideration as an addition to KSMA policy.

The Council discussed in detail the final reports of the committees and submitted these to the Board of Trustees with the Council's recommendations.

Dental-Nurse-Pharmacy Committee

Melvin J. Weber, M.D., Ludlow, Chairman

Louisville **July 2, 1964**

The recent National Congress on Medicine and Pharmacy was discussed. The committee considered suggestions for local consideration that grew out of the Congress and made recommendations to the House of Delegates.

Activities at the last session of the Legislature relating to the areas in which the committee is interested were reported on and discussed. Following this discussion, additional recommendations were made by the committee to the House of Delegates.

Committee on Industrial Medicine

Gradie Rowntree, M.D., Louisville, Chairman

KSMA Headquarters **June 17, 1964**

The KSMA Industrial Medicine Committee held its initial meeting of the year during June and conducted a detailed discussion on the duties of the Committee which were approved and submitted to the Council on Allied Professions and Related Groups.

The Committee voted to meet sometime in the future with representatives of the insurance industry to determine how to best improve the health of the working population and to discuss the relations in this area existing between insurance carriers and industrial medicine physicians.

STAFF PHYSICIANS FOR FULL - TIME APPOINTMENT

VETERANS ADMINISTRATION HOSPITAL

LEXINGTON, KENTUCKY

There are openings for several full-time staff Physicians at this predominantly psychiatric hospital with expanding medical, surgical and geriatric services. Salary $9980 to $18,240 depending on qualifications; liberal fringe benefits. Excellent cultural and educational opportunities in community. Visit for personal interview can be arranged at our expense. Moving costs to Lexington will be paid. Write or call Director, V. A. Hospital, Lexington, Kentucky.

NEW MEN'S SHOP



. . . in our NEW SOUTHERN

OPTICAL BUILDING, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

GUILD OPTICIANS

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK

News Items

John H. Neyer, M.D., Ashland, was recently named president of the United Cerebral Palsy Association of Eastern Kentucky. Doctor Neyer limits his practice to obstetrics and gynecology.

Edwin H. West, M.D., has been appointed as a staff physician at the Veteran's Administration Hospital in Lexington, it was announced recently. Dr. West, a former director of Kentucky local health services for the State Department of Health, has been in private practice at Olive Hill since 1962.

Carl B. Rankin, M.D., has become associated with **Morris Flexner, M.D.** and **James Bryan, M.D.,** in Louisville, and will limit his practice to internal medicine. Doctor Rankin is a 1959 graduate of the University of Tennessee College of Medicine and was in private general practice at Cadiz for one year before entering his residency at Louisville General Hospital.

Ruby A. Arnsparger, M.D., will share the office of **Peggy Howard, M.D.,** in Louisville, and will limit her practice to that of obstetrics and gynecology. Doctor Arnsparger graduated from the University of Louisville School of Medicine in 1959. Following internship at Charity Hospital in New Orleans, she completed her residency at St. Joseph Infirmary in Louisville.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

Special Article

Continued from Page 604

looking a pleasant view of the duck pond.[20] And there is a building, erected for utility rather than beauty, used for the education of students in science, that proudly bears his name.

BIBLIOGRAPHY

1. *Caron's Directory of the City of Louisville,* XXIV, 1894, Louisville, Kentucky, C. K. Caron, 1894.
Caron's Directory of the City of Louisville, XXV, 1895, Louisville, Kentucky, C. K. Caron, 1895.
2. Johnston, J. S. *Memorial History of Louisville,* Chicago, American Biographical Publishing Company, 1896.
3. Deed book 429, p. 289, July 8, 1894, Jefferson County, Kentucky, Court House.
4. *Physicians and Dentist's direct cry of the States of Indiana and Kentucky,* Chicago, Galen Gonsier and Co., 1897.
5. Pope, Curran. *Practical Hydrotherapy.* Cincinnati, Cincinnati Medical Book Company, 1909, p. 168.
6. Ibid., p. 442.
7. *Jefferson County Medical Society Book,* November 31st, 1906.
8. Personal communications, Mr. John C. Rogers, Jr.
9. Pope papers. Box 1, Filson Club. Louisville, Kentucky.
10. Deed Book 1493, p.560, January 28, 1932, Jefferson County, Kentucky, Court House.
11. Deed Book 1529, p. 378, October 16, 1933, Jefferson County, Kentucky, Court House.
12. Louisville Times, September 21, 1934.
13. Will of Curran Pope, #25373, Jefferson County, Kentucky, Court House.
14. Personal communication, Ruth Donnelly, Liberty National Bank and Trust Company, Louisville, Kentucky.
15. University of Louisville Trustees records, April 13, 1938.
16. Deed Book 1002, p. 447, April 3, 1922. Jefferson County, Kentucky, Court House.
17. University of Louisville Trustees records, February 5, 1941.
18. University of Louisville Trustees records, February 7, 1947.
19. University of Louisville Trustees records, January 25, 1950.
20. Lot 64 Section G Cave Hill Cemetery, Louisville, Kentucky.

GET IN THE MIDDLE of THINGS . . .

Heyburn Building

The preferred professional address

A central location at the hub of public transportation; adequate nearby parking. Complete service with uniformed attendants.

All specialties are represented in The Heyburn Building. This has proven to be most helpful where consultation is indicated.

For information, contact:

DOWNTOWN LOUISVILLE MANAGEMENT, INC.
1401-A Heyburn Building **587-6982**



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

313-4

IN THE BOOKS

GASTROENTEROLOGY, Volume II, (Second Edition): edited by Henry L. Bockus, M.D. Published by W. B. Saunders Co., Philadelphia; 1964; 1241 pages; Price, $28.00.

This is the second volume of a three volume set covering the entire field of gastroenterology. The 36 contributors to this volume have all been associated with Dr. Bockus at the University of Pennsylvania Graduate School of Medicine.

The re-writing of his classic reference work has been a monumental task. The pathophysiology of disease processes has been emphasized throughout, but the book is written from a clinical orientation.

This volume covers the small intestine. absorption and nutrition, the colon, peritoneum, mesentery and omentum. The chapters on primary and secondary malabsorption syndromes and clinical application of tests for these syndromes are particularly well written. Regional enteritis and ulcerative colitis are also well covered.

Apparently not much emphasis was placed on terseness. A three page chapter is devoted to fecal impaction and contains 11 references. The chapter on the appendix contains 30 pages and 149 references. The volume is well indexed and references are current through 1962.

Of the three volumes, this one probably will be of least general clinical interest. The third volume covering the hepato-biliary system, pancreas and secondary gastrointestinal disorders is scheduled for printing in 1965.

This volume is the most complete, if not the most succinct, reference work on the subject matter covered. I anticipate with pleasure the appearance of the third volume.

F. Norman Vickers, M. D.

PATIENT CARE AND SPECIAL PROCEDURES IN X-RAY TECHNOLOGY, Second Edition: by Carol Hocking Vennes, R.N., B.S., and John C. Watson, R.T. Published by The C. V. Mosby Company, St. Louis, 1964; pages; price, $6.25.

The authors combine the training and talents of instructors of nursing and x-ray technology. This second edition, the first published in 1959, is designed to elucidate the newer developments of radiology, particularly those dealing with angiography.

Most books dealing with the subject of x-ray technology stress the physical aspect of the equipment used and deal in detail with problems of examining each part or system of the body. This book has as its primary function the introduction of the student in x-ray technology to the handling of patients. It will probably serve better than any other text to improve the relationship of the technician to the patient and permit him to consider more fully the comfort and convenience of the patient.

The technician is shown what his position is in the medical team and what his duties are relative to the patient and to the members of the x-ray team. The hazards involved in radiography as well as fluoroscopy are elucidated. The steps in the patient's preparation and handling are discussed in the light of the physiological processes involved in the various examinations. Since many patients are either seriously ill or have been recently injured, a considerable portion of this text is directed toward giving the technician the proper understanding of nursing procedures so that the patient may be safely and comfortably handled. Even the safety of the technician in the handling of the patient is discussed.

The book is sub-divided in such a way that the general procedures with simpler nursing problems are discussed separately from the special procedures that require more complicated handling. Detailed instructions are given to the technician so that he may prepare for the various special procedures involved in neuro-radiography, angiography, gastrointestinal radiography, and so forth.

All students of x-ray technology should read this book early in their training. They would be more understanding of their patients. They would also be better members of the medical team.

Gerald M. Peterson, M.D.

APPRAISAL OF CURRENT CONCEPTS OF ANESTHESIOLOGY: Edited by John Adriani, M.D.; published by C. V. Mosby Company, St. Louis, 1964. 468 pages; price,$10.75.

Doctor Adriani and his colleagues in the anesthesia department of Charity Hospital in Louisiana have prepared a very excellent digest of recent literature presented in the format of reviews of especial significance to medical specialists concerned with anesthesiology.

The book crosses many boundaries and information contained therein would be of interest to all medical personnel who deal with the anesthetized or unconscious patient. The topics selected range from the placental transmission of drugs to some aspects of xenon anesthesia. A very significant number of the reviews in this volume deal with hormones as they influence anesthesia technique and management.

The subject matter is more up to date than most classic textbooks and a definite attempt is made to direct the reviews towards clinicians. They are not intended to be useful to research workers as they are not exhaustive or complete in massive detail. The book is easy to read and the material is clearly presented.

Peter P. Bosomworth, *M.D.*

Why

RECOMMEND
BLUE SHIELD?



Because

BLUE SHIELD
PROVIDES
A UNIQUE
KIND OF
MEDICAL-SURGICAL PROTECTION
MORE KENTUCKIANS COUNT ON

No member has ever been cancelled because of age, health, retirement, or an incurable condition.

Eligible dependents of deceased members, and children reaching age 19 marrying before age 19 may continue protection. Members may transfer from one group to another —one state to another. Kentucky Blue Shield offers a variety of Plans and broad range of benefits . . . . ON A VOLUNTARY BASIS . . . . for families, individuals, and eligible groups.

BLUE SHIELD - BLUE CROSS

Medical-Surgical Protection — Companion Plan for Hospital Protection

KENTUCKY PHYSICIANS MUTUAL, INC. • BLUE CROSS HOSPITAL PLAN, INC.

3101 Bardstown Road • Louisville, 40205 • Phone 452-1511

In Memoriam

JOHN GRAHAM ARCHER, M.D.
Prestonsburg, Ky.
1908 - 1964

John G. Archer, M.D., 55, Prestonsburg, a former trustee for the 14th KSMA Trustee District and a past president of the Kentucky Academy of General Practice, died July 4 at McDowell Appalachian Hospital. Doctor Archer, a former member of the Prestonsburg city council, graduated from the University of Louisville School of Medicine in 1933. He was the uncle of KSMA President George P. Archer, M.D.

EARLE SCOTT LEWIS, M.D.
Mouthcard, Ky.
1896 - 1964

Earle S. Lewis, M.D., 68, who had practiced general medicine at Mouthcard in Pike County since 1946, died June 23 at Bristol, Va. Doctor Lewis, a native of Johnson County, graduated in 1928 from the Kansas City, Missouri, College of Medicine and Surgery.

MARTIN AUGUSTUS YELTON, M.D.
Burlington, Ky.
1878 - 1964

Martin A. Yelton, M.D., 85, retired Boone County practitioner, died June 30 at his home in Burlington. Doctor Yelton, who retired two years ago, had practiced general medicine in that area for 50 years. A 1905 graduate of the University of Louisville Medical Department, he was a native of Bracken County.

Henry W. Post, M.D., Louisville, has been named by Kentucky Governor Edward T. Breathitt to a two-year term on the newly formed Advisory Committee for the Blind. The group of 19 advisors will promote the awareness of and the use of all the available abilities, talents and skills of the blind by trade and industry.

MT. HOLLY
NURSING HOME

A Nursing Home with Hospital Standards



- *24 Hour Personal, Medical and Nursing Care supplemented by Closed Circuit Television.*
- *Balanced and Therapeutic Diets.*
- *Facilities for Orthopedic, Geriatic and Medical Patients.*
- *Leisure time activities.*

MT. HOLLY NURSING HOME
OFF BROWNSBORO ROAD 897 - 1646



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #165. This 28 year old married white gravida 111 para 11 had her last menstrual period the 26th of September, 1959. The patient's initial pregnancy had been terminated in 1949 by caesarean section after acute recurrent attacks of pyelonephritis that had required hospitalization on four occasions. The etiology of the recurrent urinary tract infection was established as being due to ureteral obstruction. The second post operative day a unilateral nephrostomy was performed. On the fourth post operative day the abdominal incision dehisted with evisceration. An uneventful repair was apparently accomplished. Following this a nephrectomy was performed. A second pregnancy was reported uneventful and was delivered by caesarean section.

In 1959 the patient had a mitral commissurotomy, with a good functional result. During operation the phrenic nerve was injured and the patient was left with unilateral paralysis of the diaphragm.

During the present pregnancy the patient had fluid retention. She received diuretics and salt restriction. She was admitted to the hospital at 36 weeks gestation and digitalized. At 38 weeks with a normal blood count an elective repeat caesarean section under spinal anesthesia was carried out uneventfully. Post operatively the patient was placed in an oxygen tent and some three hours after surgery her blood pressure was noted to be 90/50 with a pulse rate of 100. At this time her skin was described as cold and clammy. Oxygen therapy was continued and the foot of the bed elevated. Six and a half hours after surgery the patient received 500 cc's of whole blood and a vasopressor because of persistent hypotension. Despite this her blood pressure became unobtainable. A blood count at the time revealed the hemoglobin of 12.9, a RBC of 4,700,000, and a white count of 17,250.

Approximately 13 hours after surgery the patient continued to have hypotension and 500 cc's of dextrose and saline was started with the addition of 4 ampules of noradrenalin. Adrenal corticosteroids were given intramuscularly. Blood pressure was maintained at 95/55 as long as the noradrenalin drip was continued. A repeat blood count showed a hemoglobin of 12.0 gms per cent and the RBC was 4,300,000.

Twenty-four hours after surgery an attempt was made to administer a second unit of whole blood, but the patient's blood pressure was unobtainable without the noradrenalin infusion. A blood count at this time revealed a hemoglobin of 8.7 gms per cent, RBC of 3,000,000. During the afternoon of the first post operative day three more units of whole blood were administered and the patient's blood count at that time was noted to be 10.6 gms per cent. Late in the evening of the first post operative day the patient complained of chest pain.

On the morning of the second post operative day the patient's hemoglobin was 9.9 gms per cent with a RBC of 3,500,000. A sixth unit of whole blood was administered. Her respiratory rate became more labored and large amounts of mucous were suctioned from the nose and mouth and the patient expired approximately 50 hours after her initial surgery.

At autopsy the abdominal cavity contained 1500 cc's of liquid blood and blood clots. There was no single point indicating location of bleeding. Microscopic examination of the incisional site in the uterus showed the healing process to be well established. The final pathologic diagnosis was rheumatic heart disease with pulmonary edema and hemoperitoneum.

The committee classified this case as a direct obstetrical preventable death. Peripheral blood counts do not reflect true whole blood volume in the immediate post operative period. Hypotension at this time in a relatively healthy young female should be attributed to hemorrhage until proven otherwise.

This patient's hypotensive tendency and the requirement for pressor drugs after what was felt to be a routine caesarean section should have alerted the attending physician to the possibility of concealed massive hemorrhage. The opportunity for effective therapy was lost one hour postoperatively when supportive measures were initiated in the treatment of the

patient's hypotension rather than an investigation of possible hemorrhage. It is conceivable that spinal anesthesia could have led to this difficulty but the patient had full return of sensation and motor function at the onset of the hypotension.

Sympathetic blockade outlasts sensory anesthesia, but this factor could have been eliminated as an etiologic agent at the time the vasopressor was started. The combined use of a vasopressor and whole blood further confused the picture. Rapid infusion of 500 cc of whole blood prior to the use of a vasopressor might have identified the problem as one of hypovolemia. Hemoglobin determinations are generally unreliable in following or identifying acute blood loss until 12 to 24 hours following surgery.

The history of previous renal and cardiac disease may have influenced the treatment to the extent that rapid blood infusion was avoided. However, it was felt that the persistent administration of large amounts of fluid, in a patient with known rheumatic heart disease, who had required prophylactic digitalizion preoperatively should have further alerted the attending physician to impending disaster. Under circumstances such as these early operative exploration would be indicated in an attempt to achieve surgical correction of the hemorrhage.

Paroxysmal Ventricular Fibrillation

Continued from Page 598

rents after Coronary Occlusion, Am. Jour. Physiology 113:683-689 1935
2. Lown, Bernard, Amarasingham, Raghavan and Neuman, Jose, New Method for Terminating Cardiac Arrhythmias, JAMA 182:548-555 1962
3. Brofman, Bernard L., Leighninger, David S., and Beck, Claude S. Electric Instability of the Heart: The Concept of the Current of Oxygen Differential in Coronary Artery; Disease Circ. XIII: 161-177 1956
4. Badeer, Henry S., Importance of Oxygen Differentials in Etiology of Ventricular Fibrillation after Ligation of Coronary Artery; Am. Heart J. 63:374-380 Mar. '62
5. Schwartz, S. P. & Jezer, A., Action of Quinine and Quinidine on Patients with Transient Ventricular Fibrillation; Am. Heart J. 9:792 1934
6. Miller, H., Nathanson, M., & Griffith, G. C.; The Action of Procaine Amide in Complete Heart Block; Am. Heart J. 44:432 1952
7. Kouwenhoven, W. B., Jude, J. R., and Knickerbocker, G. G.; Closed-Chest Cardiac Massage; Jama 173:1064-67 July 1960

Charles H. Nicholson, M.D., has entered the practice of general and thoracic surgery at Lexington, where he will be associated with the Lexington Clinic. Doctor Nicholson graduated in 1955 from Vanderbilt University School of Medicine and completed both his internship and residency at the University of Rochester, New York. Prior to coming to Lexington he was a senior instructor in surgery at the University of Rochester.



- PETN (pentaerythritol tetranitrate) to increase oxygen supply
- plus meprobamate to decrease anxiety and tension

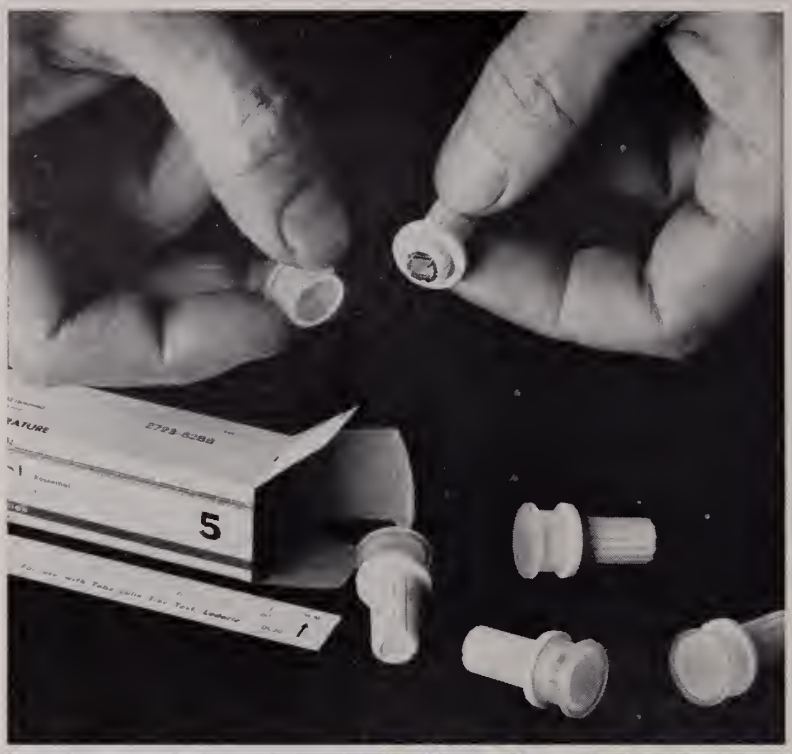
Unlike phenobarbital, meprobamate is *not* cumulative and does *not* cause depression.

Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. **Precautions:** Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. **Contraindications:** Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* **Dosage:** 1 to 2 tablets, *before meals* and at bedtime. Individualization required. **Supplied:** Bottles of 50 tablets.

CML-1055

MILTRATE®
meprobamate 200 mg. + pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*







TAKE 5

...and find that a TB screening test has never been quite so easy

SWAB THE ARM— UNCAP A TINE TEST— PRESS—DISCARD THAT'S ALL THERE IS TO IT.

Comparable to the Mantoux in accuracy and sensitivity, the TUBERCULIN, TINE TEST is now available in plastic-capped units uniquely suited to general practice needs. They are so simple to use that you can test every patient with ease. Since it requires no refrigeration, the new package of five Tine Test units can stand on any convenient table in your examining rooms, ready for routine use. Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis.

available as the new individually-capped unit, boxes of 5, or in cartons of 25

TUBERCULIN, TINE TEST

(Rosenthal) Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. 7899-4

Lederle

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lossiter, Representotive
203 Porkside Building, 4140 Shelbyville Road, Louisville 7
Mailing Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses

KENTUCKY STATE MEDICAL ASSOCIATION

OFFICERS — 1963-1964

GEORGE P. ARCHER, Prestonsburg ..... President
DELMAS M. CLARDY, Hopkinsville ..... President-Elect
DAVID M. COX, Louisville ..... Immediate Past President
CARLISLE MORSE, Louisville ..... Vice President (Central)
CARL C. COOPER, Bedford ..... Vice President (Eastern)
JOHN DICKINSON, Glasgow ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, Corbin ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
DOUGLAS E. SCOTT, Lexington ..... Chairman of the Board of Trustees
GABE A. PAYNE, JR., Hopkinsville ..... Vice Chairman of the Board of Trustees

DELEGATES TO THE A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

BOARD OF TRUSTEES

First District ..... O. LEON HIGDON, 2515 Broadway, Paducah 1965
Second District ..... HOWELL J. DAVIS, 330½ Allen Street, Owensboro 1964
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville (serving interim term) 1964
Eighth District ..... DON JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1964
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1964
Eleventh District ..... HUBERT C. JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... CLYDE C. SPARKS, Mayo Arcade, Ashland 1964
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

BUYERS GUIDE

JOURNAL OF THE KSMA BUYERS GUIDE FOR AUGUST, 1964

Ames Company 641
Baker Laboratories 625
Blue Cross Hospital Plan 633
Burroughs Wellcome 621
Coca-Cola Company 629
Downtown Louisville Management, Inc. 630
The Keeley Institute 630
Wm. Kendrick Jewelers, Inc. 624
KEMPAC 612
Lederle Laboratories S73-S78-S79-617-626-627-631-638
Eli Lilly & Company S80
Madison State Hospital 619
Medical Protective Company 639
Mt. Holly Nursing Home 634
New Castle Sanitarium 639
Parke, Davis & Company 568
A. H. Robins Company S74-S75
Roche Laboratories 642
W. B. Saunders Co. 569
G. D. Searle & Company 607
Southern Optical Company 629
Smith Kline & French 615
V. A. Hospital 628
Wallace Laboratories S77-610-611-623-635-637
Winthrop Laboratories S71



"the same old story, doctor—indigestion"

The patient's complaint is indigestion...especially of intolerance to fried foods...aggravated by stress. You diagnose functional G.I. disturbance and associated stress...as manifested by flatulence, "nervous" indigestion and constipation. Prescribe

DECHOLIN-BB®

(Hydrocholeretic • Antispasmodic • Sedative, AMES)

Each Tablet Contains:

BUTABARBITAL SODIUM.....15 mg (¼ gr)
(Warning: May be habit forming) to ease nervous tension

DEHYDROCHOLIC ACID.....250 mg (3¾ gr)
to produce large volume of watery bile, hydrate the bowel contents and gently stimulate the intestinal mucosa

BELLADONNA EXTRACT.....10 mg (⅙ gr)
to reduce smooth-muscle hypertonus

Average adult dose: 1, or if needed, 2 tablets three times daily. *Precautions:* Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction. Caution drivers against possible drowsiness. *Side effects:* Dehydrocholic acid may cause transitory diarrhea; belladonna — blurred vision, dry mouth. *Contraindications:* Biliary tract obstruction, acute hepatitis, glaucoma, and prostatic hyperplasia. *Available through your regular supplier:* DECHOLIN-BB, bottles of 100 tablets. 72664

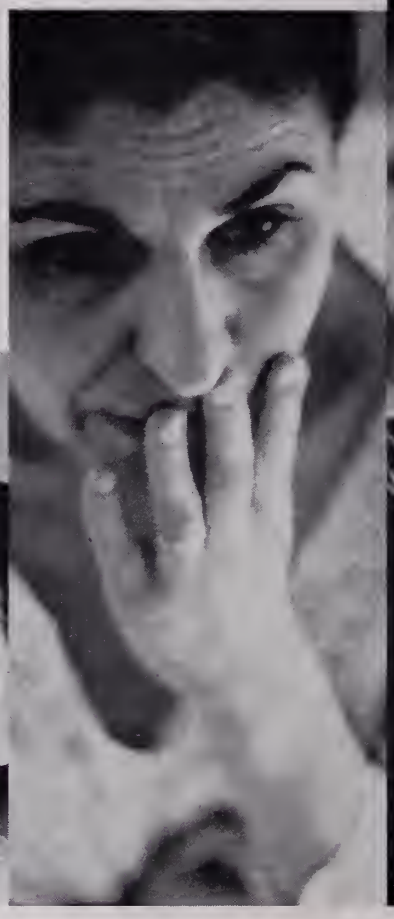
Ames Company, Inc., Elkhart, Indiana. AMES

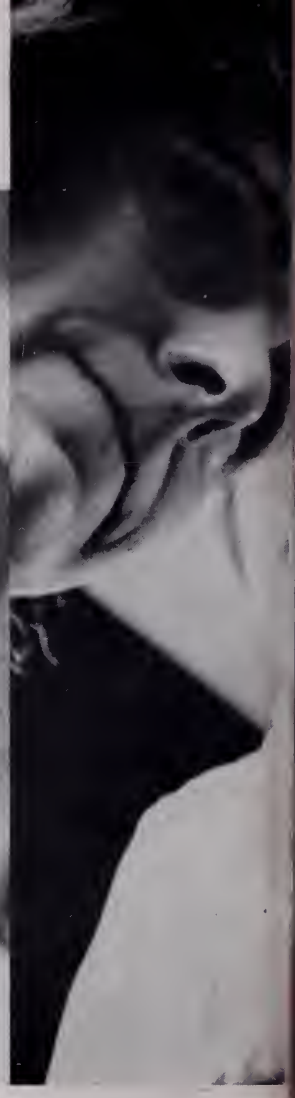
when psychic tension mounts

Valium®
(diazepam)

useful in alleviating
— psychic tension in the common psychoneuroses
— psychic tension related to situational stress
— psychic tension intensified by concomitant somatic components







ROCHE

How to prescribe Valium (diazepam)

Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue. Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal. Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in dealing with psychotic patients manifesting anxiety and should be avoided when there is reason to believe the patient is psychotic.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) a other psychotropic agents is not recommended. If such combination thera is used, careful consideration should be given to the pharmacology of t agents to be employed with Valium (diazepam) — particularly with kno compounds which may potentiate the action of Valium (diazepam), su as phenothiazines, barbiturates, MAO inhibitors and other antidepressan

Since Valium (diazepam) has a central nervous system depressant effe patients should be advised against the simultaneous ingestion of alcohol a other central nervous system depressant drugs during Valium (diazepa therapy. Safe use of Valium (diazepam) during pregnancy has not b established. The usual precautions are indicated when Valium (diazepam used in the treatment of anxiety states where there is any evidence of i pending depression; particularly the recognition that suicidal tendencies m be present and protective measures may be necessary. The usual precauti in treating patients with impaired renal or hepatic function should be served.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been ported; in most instances these are dose-related and may be avoided proper dosage adjustment. Mild nausea and dizziness may occur on occasi As with any new agent, when it is administered for protracted periods time, periodic blood counts and liver function tests are advisable. Abr cessation after prolonged overdosage may, in some patients, produce wi drawal symptoms (*e.g.*, convulsions, tremor, abdominal and muscle cram vomiting, sweating) similar to those seen with barbiturates, meprobam and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have b observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep turbances, acute hyperexcited states and hallucinations have been report Other side effects noted have been blurred vision, diplopia, headache, continence, slurred speech, tremor and skin rash.

Valium (diazepam) is available as 5-mg and 2-mg tablets. For convenie and economy in prescribing, both strengths are supplied in bottles of

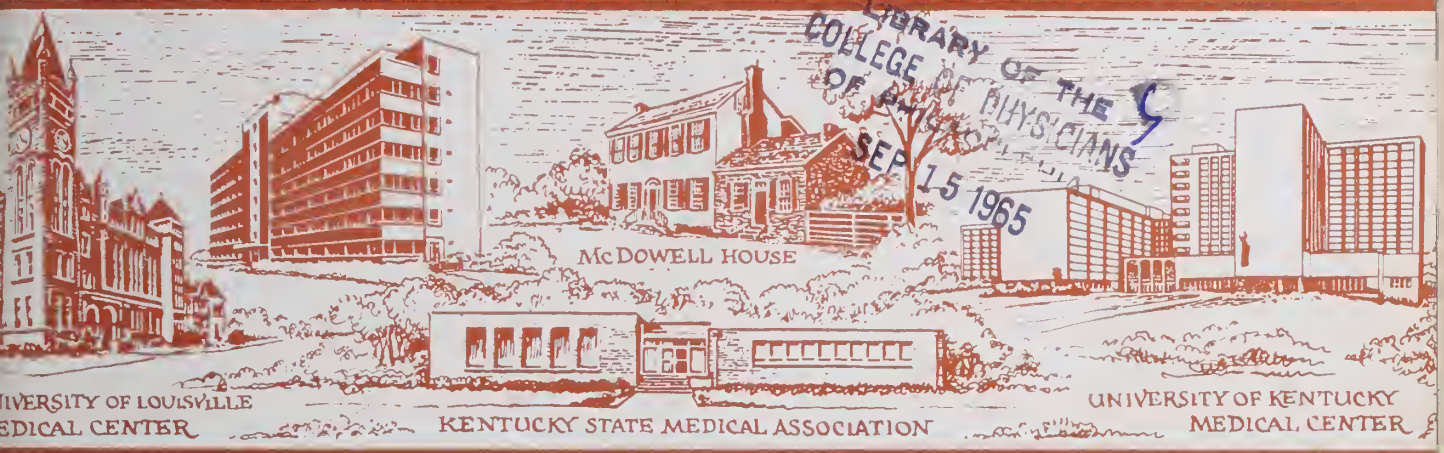
ROCHE LABORATORIES
Division of Hoffmann - La Roche Inc / Nutley, N. J. 07110

SEPTEMBER 1964 • VOLUME 62 • NUMBER 9

Annual Meeting Issue

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



LIBRARY OF THE COLLEGE OF PHYSICIANS
SEP 15 1965

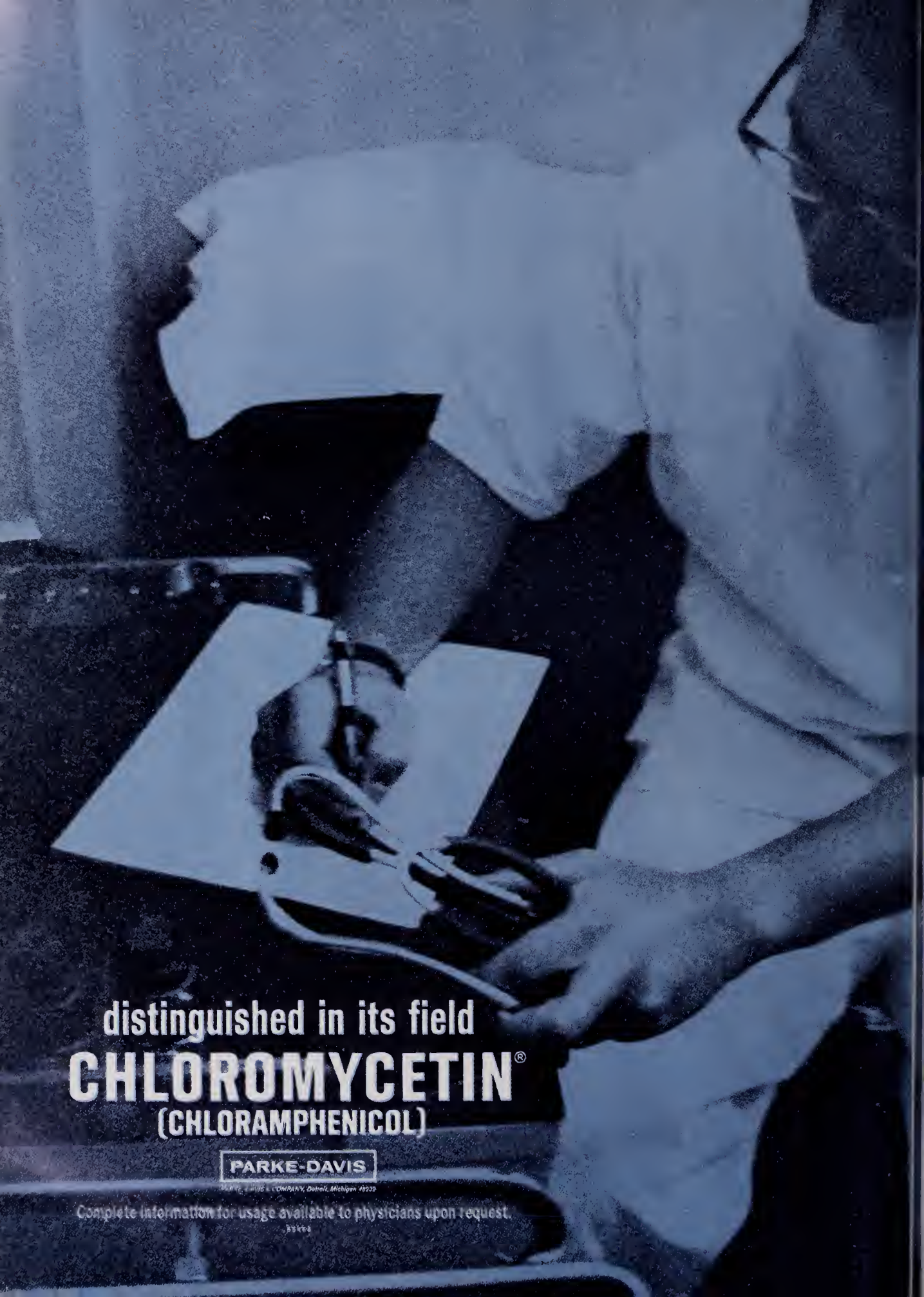
In This Issue

Urinary Tract Infection—Past, Present and Future
David M. Davis, M.D. 661

Complete Information on KSMA Annual Meeting 678

- Scientific Sessions
- Specialty Group Meetings
- Business Meetings

Complete contents on page 646


distinguished in its field
CHLOROMYCETIN®
(CHLORAMPHENICOL)
PARKE-DAVIS
PARKE, DAVIS & COMPANY, Detroit, Michigan 48232
Complete information for usage available to physicians upon request.



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

279-4

VOLUME 62 • SEPTEMBER 1964
Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Sam A. Overstreet, M.D.

• ASSOCIATE EDITOR
Wolter S. Coe, M.D.

• MANAGING EDITOR
J. P. Sanford

• ASST. MANAGING EDITOR
Ann M. Huntsmon

• DEPARTMENTAL EDITORS
Jack L. Chumley, M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscar J. Hoyes, Cose Discussions
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR
George F. Brockman, M.D., Chairman
Willett H. Rush, M.D.
Blaine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Moore, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1967
Edward C. Groves, M.D.
Corl W. Kumpe, M.D.
Marvin A. Lucos, M.D.
Robert N. McLeod, Jr., M.D.
Henry W. Past, M.D.
Clinton R. Potts, M.D.
Oscar Thompson, M.D.
George I. Uhde, M.D.

Term Expires July 1, 1966
Harold L. Bushey, M.D.
Edword J. Fodell, M.D.
Merle W. Fowler, Jr., M.D.
Joseph L. Goldstein, M.D.
John D. Lovett. M.D.
George F. McAuliffe, M.D.
Rolph G. Thomos, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965
McHenry S. Brewer, M.D.
Lewis Dickinsan, M.D.
Zygmunt Gierloch, M.D.
Douglos L. Gillim, M.D.
Arthur H. Keeney, M.D.
Jomes B. Stith, M.D.
Chester B. Theiss, M.D.
Kearns R. Thompsan, M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205
Subscription $8.00—single copy .80
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

Urinary Tract Infection—Past, Present and Future
David M. Davis, M.D. 661

SPECIAL ARTICLE

On Succeeding in Medicine
Harlan English, M.D. 670

EDITORIALS

It Ranks With The Best 672

Remember the Southern 673

As Others See Us 673

ANNUAL MEETING SECTION

Program in Detail 678

ORGANIZATION SECTION

Health-O-Drama to be Feature of 1964 Kentucky State Fair 704
Dr. McPheeters Resigns Post as Mental Health Head 704
Ky. Pharmacists Elect Officers at July French Lick Meeting 704
AMA Disaster Care Meeting Held in Louisville 704
Automotive Medical Association to Meet in Louisville 705
Dr. Parks is New Chairman of U.K. Anatomy Dept. 705
KAGP Has Two-Day Seminar at Cumberland Falls 705

REGULAR FEATURES

Public Health Page 654
Postgraduate Page 713
In The Books 720
President's Page 648
Answers to Your Questions on Blue Shield 728



NTz Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

NTz® Nasal Spray

NTz is more than a simple vasoconstrictor. It contains [N]eo-Synephrine® HCl 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; [T]henfadil® HCl 0.1% for topical antiallergic action; and [Z]ephiran® Cl 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium as chloride, refined), trademarks reg. U. S. Pat. Off. 17961M

Winthrop **Winthrop Laboratories New York 18, N.Y.**

MESSAGE FROM THE PRESIDENT



A Year Well Spent

IT IS incredible to me but none the less true that my term of office as president of this great organization is about to come to an end. I have had a rich and rewarding experience as your president and I am grateful to the membership for permitting me to serve as head of the KSMA for a period of time.

Our organization has been quite active in the months since last September and it has faced up to a number of difficult problems, for this I congratulate the loyal members of the Board of Trustees, and the various councils and committees.

I have found the Woman's Auxiliary a source of strength to the parent organization. Indeed, Mrs. J. Murray Kinsman, the president, and the other fine women who are most active in this group, gave proof once again that the auxiliary is truly an auxiliary. That is, it aids, assists and supports the state society in its multifarious activities.

It has been my pleasure to work with and observe our Executive Secretary, Mr. Joseph P. Sanford and I can testify to his personal creed that has exhibited inflexible adherence to principle, truth, accuracy and unselfish devotion to duty. He has been a steadying influence to the Medical profession of the State of Kentucky and has built for the KSMA a loyal and efficient staff that is second to none in this nation.

Before I conclude, I should like to thank the many physicians and their wives who have been so cordial to me and my wife, Margaret, during my visits to their communities—and I am happy to report that we invariably received a warm and friendly welcome.

I should like to thank the AMA Delegates, Board of Trustees, the various council chairmen and members, the committee chairmen and committee members for their help and support during my term in office. It has been of great interest to me to observe during the past 12 months how much hard work all these people do on your behalf and in the interest of KSMA. If there were more awareness of this dedication to the future of the profession, perhaps greater numbers of members would take part in society affairs and try to make it an even better organizational tool.

And last but not least, I wish to thank Dr. Douglas Scott for his leadership of the Board of Trustees for the past 12 months. Without his drive and grasp of Medical and other issues, I doubt whether the society would have accomplished as much as it has.

George O. Archer M.D.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193



HOW TO BE SURE
your young patients get the aspirin dosage you want them to have

The answer is Orange Flavored Bayer Aspirin for Children

The dosage is 1¼ grains per tablet. Mothers place such confidence in the Bayer name. And the new orange flavor is so fresh and smooth that children take it readily. (The grip-tight cap on the bottle helps keep them from taking it on their own.)

For professional samples, just write The Bayer Company, Dept.112, 1450 Broadway, New York 18, New York.





Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

Note:
Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae*.

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Cured with Signemycin
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017

"If food makes him feel good, it is not at all surprising that he will turn to it when times are tough, and his tension mounts."[1]



ESKATROL® Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

SPANSULE®

brand of sustained release capsules

controls appetite all day long with a single morning dose

relieves the emotional stress that causes overeating

Brief Summary of Principal Side Effects, Cautions and Contraindications

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

Cautions: 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

Contraindications: Hyperexcitability, hyperthyroidism.

Before prescribing, see SK&F Product Prescribing Information.

Supplied: Bottles of 50 capsules.

1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

Smith Kline & French Laboratories SK&F



Of 507 patients with confirmed ear, nose and throat infections... 465 or 91.7% were treated successfully with Signemycin®

Note:
Adams,* whose 50 patients included 20 with ENT infections, stated that Signemycin "was particularly valuable in infections that did not respond to other antimicrobial agents, and in patients to whom penicillin could not be given." All his cases responded within five days; in most patients, all signs of infection disappeared in three days.

*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Cured with Signemycin
Otitis media	90	86
Pharyngitis and laryngitis	162	148
Sinusitis	68	55
Tonsillitis and peritonsillitis	163	153
Various	24	23
Totals	507	465 (91.7%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017

PUBLIC HEALTH PAGE

The Kentucky Heart Clinics*

RUSSELL E. TEAGUE, M.D., M.P.H.
Commissioner of Health
Commonwealth of Kentucky

Although many physicians are already familiar with the activities of the regional heart clinics, the purpose of this article is to clarify the functions of the itinerant heart clinics and bring you up to date on their current status. As you know, the itinerant heart clinics are sponsored by the Heart Disease Control Program of the State Health Department in cooperation with the Kentucky Heart Association. These clinics have been held in Henderson, Bowling Green, Hopkinsville, Mayfield, Campbellsville, London, Owensboro, Irvine, Morehead, Prestonsburg, Maysville, Manchester, Hazard, Pikeville, Beattyville, and Harlan. The consultant clinic personnel are provided by the University of Louisville School of Medicine and the University of Kentucky College of Medicine.

The functions of the heart clinics are in three major areas: (1) Service to patients; (2) education; and (3) research.

Service to patients consists of:

(1) Making available the best current knowledge and techniques in diagnosis and treatment.

(2) Providing diagnostic or therapeutic consultant services to other clinics, physicians, and health agencies in the community.

(3) Providing continuity of care by appropriate follow-up measures and

(4) Providing adequate counseling and other ancillary services necessary for patient care to enable patients to make social adjustments and to assume responsibility for their own care.

The clinics serve as an educational medium by providing opportunities for advancing the professional experiences of physicians, and advancing education of nurses, social workers, and other professional personnel. In addition, it affords the opportunity to inform patients and their families about those aspects of cardiovascular diseases which they should understand in order to facilitate their own care. Arrangements are made wherever feasible, for the regular attendance at clinic sessions and conferences by interns, residents, student nurses, and other professional workers as part of their hospital training. This brings the resources of our two medical centers in closer contact with the more distant communities which they serve. A third and vital function of the itinerant heart clinics is to provide facilities and opportunities for clinical, administrative, social, and epidemological investigations by interested personnel from our medical schools and our State Health Department.

These heart clinics which have been in operation since 1954 have had the support of the Kentucky State Medical Association and have been established at the request of County Medical Societies. Patients are accepted at heart clinics only on a physician's referral. Prior to holding a clinic, the Kentucky Heart Association writes each physician in the clinic area giving the time, date, and location of the clinic so they may make desired referrals of their patients. On the day preceding a clinic a field worker for the Heart Association assists the county health department staff with the necessary preparations. In addition to arranging for clinic services with physicians and medical schools the Heart Disease Control Program makes available the necessary equipment and additional personnel for the clinics which are held in the county health departments.

We are all quite proud of the work of our heart clinics and hope that they will receive your continuing support.

**This article was prepared by Stephen G. Edelstein, M.D., Heart Disease Control Officer, Kentucky State Health Department, 275 East Main Street, Frankfort, Kentucky*



Of 1,021 children with various confirmed infections... 950 or 93.0% were treated successfully with Signemycin®

Note:
The effectiveness of Signemycin was demonstrated by Chattas and his co-workers* who administered Signemycin to 30 children with serious staphylococcal infections resistant to commonly used antibiotics. Only one failed to respond. In each case the use of this drug was indicated by antibiogram. Those children treated with a nonselected antibiotic—for comparative purposes—took three times longer to recover.

Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

Condition	No. of Patients	No. Cured with Signemycin
Eye, ear, nose, throat infections	368	343
Respiratory infections	369	346
Gastrointestinal infections	42	30
Skin and soft-tissue infections	38	37
Deep-seated or generalized infections	47	44
Various conditions	157	150
Totals	1,021	950 (93.0%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Signemycin is also available as half-strength Capsules, preconstituted raspberry-flavored Syrup and Pediatric Drops

Brief Summary and Bibliography follow.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017

Signemycin® Bibliography
1. Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957. **2.** Arachi, N. and Gheradi, F.: Quad. Urol. 9:156, Apr.-June, 1959. **3.** Arneil, G. C.: Antibiot. Ann. 1958-1959:327. **4.** Arrigoni, G. et al.: Minerva Med. 48:2701, Aug. 25, 1957. **5.** Baur, A.: Aerztl. Prax. 11:1845, Dec. 5, 1959. **6.** Bellomio, S. et al.: Riv. Ital. Tracoma, vol. 10, Nos. 1-2, Jan.-June, 1958. **7.** Bellomio, S. et al.: Riv. Ital. Tracoma, vol. 11, No. 1, Jan.-Mar., 1959. **8.** Belonoschkin, B. and Lindgren, M.: Svensk. Lakartidn. 56:2134, July 31, 1959. **9.** Bergdahl, U.: Svensk. Lakartidn. 55:1715, June 6, 1958. **10.** Bhattacharyya, M. N. and Bhuyan, J. N.: Antiseptic 56:611, Aug., 1959. **11.** Blass, R.: Schweiz. Med. Wschr. 89:158, Feb. 7, 1959. **12.** Bolognesi, C.: Minerva Med. 48:2695, Aug. 25, 1957. **13.** Candela, R. B.: Med. Esp. 46:273, Oct., 1961. **14.** Cappelli, E.: Minerva Med. 48:2690, Aug. 25, 1957. **15.** Carter, C. H. and Maley, M. C.: Antibiot. Ann. 1956-1957:51. **16.** Caruselli, M. and Musca, A.: Minerva Med. 51:3516, Oct. 17, 1960. **17.** Ceitlin, J.: Med. Panamer. 15:72, Aug. 1, 1960. **18.** Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960. **19.** Chiarenza, A.: Minerva Med. 48:2692, Aug. 25, 1957. **20.** Cooper, J. et al.: Antibiot. Med. 5:302, May, 1958. **21.** Cupples, J. F. B. and Perry, A. W.: Canad. Med. Ass. J. 77:699, Oct. 1, 1957. **22.** David, N. A. and Carter, P. B.: Rocky Mountain Med. J. 58:27, Mar., 1961. **23.** Davis, W. G.: Clin. Rev. 1:21, Apr., 1958. **24.** de Lellis, J.: Dia Med., Apr. 24, 1958, p. 824. **25.** Dienz, H.: Aerztl. Prax. 13:1797, 1961. **26.** Dietel, V. and Meissner, F.: Deutsch. Gesundh. 16:2470, Dec. 28, 1961. **27.** Dryjski, J.: Pol. Tyg. Lek. 24:1113, June 24, 1959. **28.** Durrieu, C. A. et al.: Antibiot. Ann. 1958-1959:297. **29.** Faz Tabio, H.: Rev. Cuba. Pediat. 30:219, Apr., 1958. **30.** Febles Alonzo, D. and Batthyany, C.: Actas Ginecotocol. (Uruguay) 13:4, Aug., 1959. **31.** Febles Alonzo, D. and Biderman, I.: Antibiot. Ann. 1958-1959:270. **32.** Fiora, F. and Compa, F.: Dia Med., Apr. 3, 1958, p. 570. **33.** Garre, E.: Antibiot. Med. 7:285, May, 1960. **34.** Geiger, K.: Praxis 15:365, Apr. 9, 1959. **35.** Gemma, G. B. et al.: Minerva Med. 48:2643, Aug. 25, 1957. **36.** Gerner, G.: Arzneimittelforschung 9.484, Aug., 1959. **37.** Grazia, G.: Clin. Pediat. (Bologna) 41:1005, Nov., 1959. **38.** Greco, O.: Med. Condotto-Med. Prat. 9:497, 1958. **39.** Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958. **40.** Henne, H. F.: Med. Klin., No. 29, July 18, 1958, p. 1267. **41.** Heredia Diaz, J. et al.: Medicina (Mex.) 38:308, July 10, 1958. **42.** Herrera, W. A.: Dia Med. 30:3116, Dec. 8, 1958. **43.** Hoffmann, H.: Medizinische (Stuttgart) 45:1830, Nov. 8, 1958. **44.** Kelleher, D.: Practitioner 182:227, Feb., 1959. **45.** Kleine, W. and Hagen, H.: Ther. Gegenw. 98:171, Apr., 1959. **46.** Klovstad, O.: T. Norsk. Laegeforen. 77:681, Aug. 15, 1957. **47.** Kobari, K. and Tajiri, I.: Naika No Ryoiki (Field of Internal Medicine) 7:245, May, 1959. **48.** Kohler, H. F.: Clin. Rev. 1:16, Apr., 1958. **49.** Kraljevic, R. et al.: Antibiot. Med. 5:364, June, 1958. **50.** La Caille, R. A. and Prigot, A.: Antibiot. Ann. 1956-1957:67. **51.** Lapeyre, L. et al.: Marseille Med. 99:953, 1962. **52.** Levi, W. M., Jr. and Kredel, F. E.: J. S. Carolina Med. Ass. 53:178, May, 1957. **53.** Loughlin, E. H. et al.: Antibiot. Ann. 1958-1959:293. **54.** Loughlin, E. H. et al.: Antibiot. Med. 7:739, Dec., 1960. **55.** Mathur, S. N. and Joshi, V. S.: J. Indian Med. Ass. 34:437, June 1, 1960. **56.** Moggian, G.: Minerva Med. 48:2648, Aug. 25, 1957. **57.** Molinelli, E. A. et al.: Antibiot. Ann. 1957-1958:692. **58.** Montilli, G. and Avellino, M.: Dermatologica (Basel) 9:2, 1958. **59.** Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716. **60.** Morador, J. L. and Saldana Tate, L.: An. Ateneo, Clin. Quirur. 1:52, Jan., 1958. **61.** Morel, A. S.: Clin. Rev. 1:18, July, 1958. **62.** Morey, G. S. et al.: Rev. Hosp. Nino (Lima) 18:293, 1957. **63.** Ottolenghi, C. E. et al.: Bol. Soc. Cir. B. Air. 41:739, Nov. 6, 1957. **64.** Pagola, J. G. et al.: Antibiot. Ann. 1958-1959:287. **65.** Pavone, M. et al.: Minerva Urol. 70:121, Sept.-Oct., 1958. **66.** Porrazzo, F.: Gazz. Med. Ital. 118:550, Dec., 1959. **67.** Prats, F. and de la Parra, M. A.: Antibiot. Ann. 1959-1960:484. **68.** Prokop, O.: Prakt. Arzt. 12:145, Feb. 15, 1958. **69.** Ramirez Boettner, C. M. et al.: Rev. Med. Paraguay 5:269, July-Sept., 1960. **70.** Randig, K.: Deutsch. Med. J. 8:447, Aug. 15, 1957. **71.** Saavedra Amaro, S. and Lopez Zepeda, L.: Medicina (Mex.) 38:396, Aug. 25, 1958. **72.** Saldana Sotomayor, F.: Medicina (Mex.) 39:191, May 10, 1959. **73.** Santos, A.: Rev. Brasil. Med. 16:463, July, 1959. **74.** Schenone, H.: Antibiot. Ann. 1958-1959:316. **75.** Schunk, A.: Int. Rec. Med. 173:143, Mar., 1960. **76.** Sgarzini, L. and Amato, R.: Ann. Stomat. 7:499, July, 1958. **77.** Shubin, H.: Antibiot. Med. 4:174, Mar., 1957. **78.** Sundberg, R. H.: Antibiot. Med. 7:115, Feb., 1960. **79.** Talbot, J. R.: Wisconsin Med. J. 57:237, June, 1958. **80.** Tato, J. M. et al.: Antibiot. Ann. 1957-1958.675. **81.** Weithofer, W.: Medizinische (Stuttgart) No. 33-34:1490, Aug. 22, 1959. **82.** Willcox, R. R. and Rosedale, N.: Brit. J. Vener. Dis. 38:19, Mar., 1962. **83.** Willemot, J. P. et al.: Bruxelles Med. 38:1026, June 22, 1958. **84.** Winton, S. S. and Chesrow, E. J.: Antibiot. Ann. 1956-1957:55. **85.** Wolman, B.: Practitioner 185:199, Aug., 1960. **86.** Yodh, B. B.: J. J. J. Group Hosp. 5:183, July, 1960. **87.** Zaldivar, C. G. and Falcone, F. L.: Rev. Hosp. Nino (Lima) 20:141, June, 1958.

SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017



Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

consistently effective...often when others fail

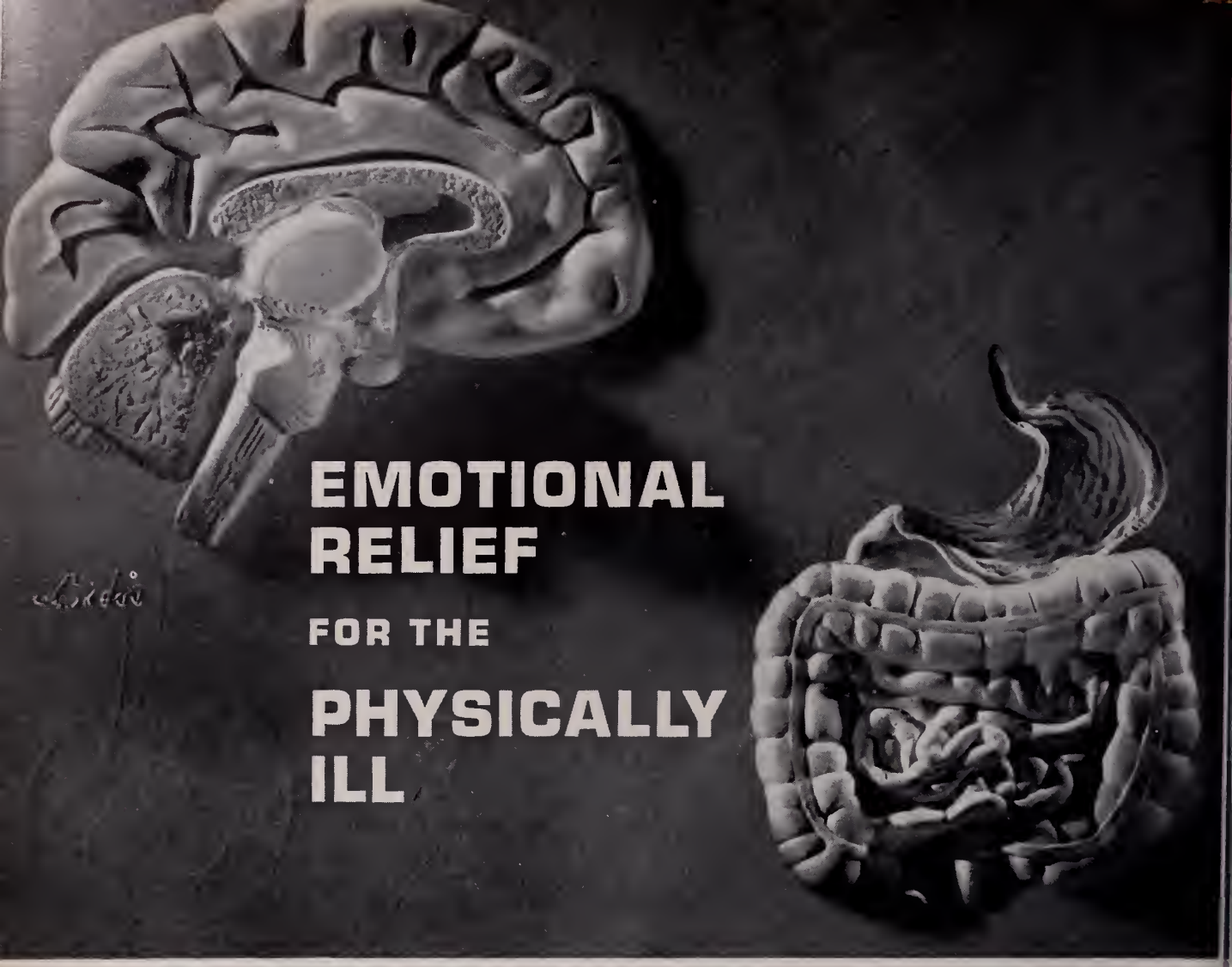
Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017



RELIEVES ANXIETY, APPREHENSION AND TENSION.



All day long
. . . keeps the patient calm, and the mind clear.



All night too
. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400

(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

CME-805

WALLACE LABORATORIES *Cranbury, N. J.*



"Wonderful...haven't had opening in both nostrils for years"*

(clearly decongested with Dimetapp)

Dimetapp lets your "stuffed-up" patients *breathe easy again.* Each long-acting Extentab works hard for up to 10-12 hours clearing away stuffiness, turning off the drip, and unplugging congestion that accompanies upper respiratory conditions. Yet, patients seldom experience drowsiness or overstimulation. (A key to success: the Dimetapp formula.) Now that the "stuffy" season is here, keep dependable Dimetapp Extentabs on tap. They get the job done.

FOR NASAL DECONGESTION IN SINUSITIS, COLDS, U.R.I.

UP TO 10-12 HOURS' CLEAR BREATHING ON ONE TABLET

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; Phenylephrine HCl, 15 mg.; Phenylpropanolamine HCl, 15 mg.)

BRIEF SUMMARY: Indications: Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. **Side Effects:** In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. **Precautions:** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. **Contraindications:** Antihistamine sensitivity. Not recommended for use during pregnancy.

*Clinical report on file, Medical Department, A. H. Robins Co., Inc.

A. H. ROBINS CO., INC., RICHMOND 20, VA.



thrown for a loss...

Keeping flies out of pharmaceutical production areas is important, yet entrances must accommodate heavy traffic of people and materials. In fact, at Eli Lilly and Company, the entrances to certain production facilities where traffic is heaviest have no screens or doors. ☐ This makes it look easy for flies to get in. But let one try it and he is literally picked up by a fast-moving blast of air and thrown for a loss—back outside. This "curtain of air," moving down and out from the top of the open doorway, bars the entrance and keeps flies out . . . still another step demonstrating the care that goes into the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

401004

The JOURNAL of the
Kentucky State Medical Association

Issued Monthly Under the Direction of the Board of Trustees

VOLUME 62 SEPTEMBER, 1964 No. 9

Urinary Tract Infection—Past, Present and Future†

David M. Davis, M.D.

Havorford, Pa.

Is all so-called "pyelonephritis" due to bacterial infection? Is all bacterial infection of the urinary tract due to the use of catheters? How should urinary tract infection be treated? A urologist discusses these important questions.

I AM indeed pleased to be invited to speak here today as an Emeritus person, twelve years after retirement from active teaching. It would not be difficult to appear as an ancient gaffer prating of the "good old days" when everything was perfect—every lass a queen, every goose a swan. I elect not to do this for the very simple reason that I know everyone listening would be bored to death. Rather do I prefer to think that the proper function for one with a long experience in his own vocation is to rub the past against the present in an effort to produce a ray of light directed into the future. The history of medicine is full of the accounts of alarms and excursions, and flights, long and short, in the wrong direction; from which our profession has had eventually to return in, it is to be hoped, a chastened and wiser state. I shall speak of such an excursion today, and hope that my forecast of the future will prove to be accurate.

†*Presented at the Tuesday, September 24 General Scientific Session of the KSMA 1963 Annual Meeting in Lexington, Ky.*

**Professor emeritus of urology at Jefferson Medical College, Philadelphia, and visiting lecturer in urology at the University of Pennsylvania Graduate School of Medicine, Philadelphia.*

Modern Concepts Begin

What might be called modern concepts of urinary tract infection began with Pasteur's discovery of micro-organisms. Very shortly thereafter Traube observed that his catheter withdrew clear sparkling urine from the distended bladder of a man with complete urinary retention, but that the following day the patient had high fever, and the urine was purulent. Thanks to Pasteur, he was able to infer that bacteria had been carried into the bladder by the catheter. Another very basic observation was that catheterization of normal persons seldom caused infection, and this led easily to the assumption that obstruction in the urinary tract brought about increased susceptibility to infection. Thirdly, it soon became evident that the urinary tract not infrequently became infected spontaneously when no catheter or other instrument had been introduced.

When the era of active experimentation began with the present century, it was shown by Brewer that injection of bacterial cultures in the renal artery caused pyogenic nephritis. Cabot and Crabtree ascertained that bacteria could not pass from the blood stream into the urine without causing destructive lesions in the kidney although such lesions might heal very quickly, leaving scars so inconspicuous that they were easily overlooked. Sweet and Stewart, of Philadelphia, proved that bacteria could ascend from the bladder to the kidney through the lymphatics of the ureter and cause pyogenic nephritis.

Here were all the fundamental facts about urinary tract infection, but concepts of treatment remained very elementary. Gross and

unmistakable obstructive lesions were removed and it was noted that infections, acute or chronic, often cleared spontaneously thereafter. At the turn of the century Albarran, with the vision of genius, reasoned that since drainage of a pus kidney through a rubber tube caused the infection to subside, normal adequate drainage through the ureter should do the same thing. However his contemporaries would not follow his inspired lead, and ureteral surgery was ignored for half a century.

Antiseptic solutions were used to irrigate the kidney, pelvis and the bladder—with very poor results. Systemic antibiotics were earnestly sought. Urotropin, acriflavine and mercurochrome were disappointing, but approximately a quarter of a century ago penicillin appeared, followed by mandelic acid, and sulfonamides, and the many broad spectrum antibiotics with which you are all familiar.

Today, however, in spite of our enormously increased knowledge of the physiology and pathology of the urinary tract, and of our fantastically improved diagnostic equipment and pharmaceutical armament, we find the medical profession involved in a bitter, obstinately waged dispute between internists and urologists as to the proper management of urinary tract infections.

Differences of Opinion

According to the ideas of the internists, bacteria, usually introduced by the catheter, grow freely in the urinary tract and produce chronic infections which are often incurable and which often eventuate in chronic pyelonephritis, uremia and death. From this concept springs the conviction, which seems to me unfounded and indeed rather naive, that all "chronic pyelonephritis", by which is meant all chronic inflammatory changes in the renal parenchyma, results from bacterial infections of the urinary tract. Consequently, the use of catheters or other instruments to investigate the urinary tract is discouraged, and all reliance is placed on treatment with drugs.

The point of view of urologists has been quite different. They have observed that perfectly normal urinary tracts have remarkable resistance to infection, so that instruments may be used in them freely and with impunity, that adequate removal of demonstrated obstructions will usually bring about spontaneous cure of infections, and that, as our instrumental equipment and experimental acumen improve, we are finding more and more obstructions of a nature and degree such that they have formerly escaped detection.

Urologists feel that the anti-catheter concept of the internists is defeatist and untenable, that it has led to the iatrogenic perpetuation of many cases of curable disease, and that the most recent events foretell its fall from popularity and eventual disappearance.

Pathological investigations fail to support its chief hypotheses. Kimmelstiel, with his collaborators Pawlowsky and Bloxdorf, in a very recent article, show from extensive autopsy studies covering 4,596 cases that the criteria for the microscopic diagnosis of pyelonephritis are exceedingly inexact and unreliable, that this so-called pyelonephritis is often present without bacteriuria, and that bacteriuria is often present without pyelonephritis. Tissue cultures are negative in many kidneys showing the microscopic picture supposed to indicate pyelonephritis. There is therefore grave doubt of the correctness of the assumption, made by many, that pyelonephritis is always the result of bacterial infection and always a corollary of urinary tract infection. In addition, the percentage of pyelonephritis found in the 4,596 cases was only 3.1 percent. We must therefore agree with Kimmelstiel and his co-workers that the chronic inflammatory interstitial lesions of the renal parenchyma so often labeled "pyelonephritis" may be, and often are, due to other things besides bacterial infection, such as toxins, vascular changes, or even perhaps viruses.

Studies of Obstructions

Urologists have proceeded actively with their own investigations. Contracture of the vesical orifice in males, so frequently in the past mistakenly identified as "chronic prostatitis," is now generally recognized. In females lower tract obstructions are seldom identifiable in routine roentgenograms and have therefore very frequently been missed entirely in the past. Now studies of bladder pressures, the rate of flow through the urethra, the voiding cystogram, besides observations with the cinefluoro-

scope during voiding, have demonstrated that there are four locations in the female urethra where congenital obstructions are likely to be found. These are shown on Fig. 1, and are, first, at the vesical orifice in the form of a congenital contracture, second, in the mid urethra in the form of valve-like folds, third, in the distal third, in the form of a congenital stenosis, and fourth, meatasltenosis.

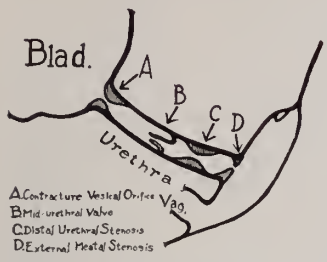


Figure 1. Common locations of narrowing (obstructions) in the female urethra.

That lower tract obstruction can cause hydroureter and hydronephrosis is shown in Fig. 2, representing a case of prostatic obstruction, and that this kind of dilatation and disfunction is reversible is shown, in the right hand panel, by complete return to normal in the same individual after relief of the obstruction. In women, contractures of the vesical orifice must be detected by very careful panendoscopic examination, noting any trigonal and detrusor hypertrophy, and such lesions as cellules and diverticula, besides voiding cystourethrograms and observations of voiding pressures and rates of flow. Not long ago it was thought that voiding cystourethrograms like that shown in Fig. 3 represented contractures of the vesical orifice with post-stenotic dilatation, analogous to that occasionally seen in large arteries. Conditions in the urethra are entirely different, however: the pressures and rates of flow are much lower, intermittent, and not pulsatile, so it is now recognized that acorn or heart-shaped dilatations, such as that shown, are not post-stenotic, but are the results of

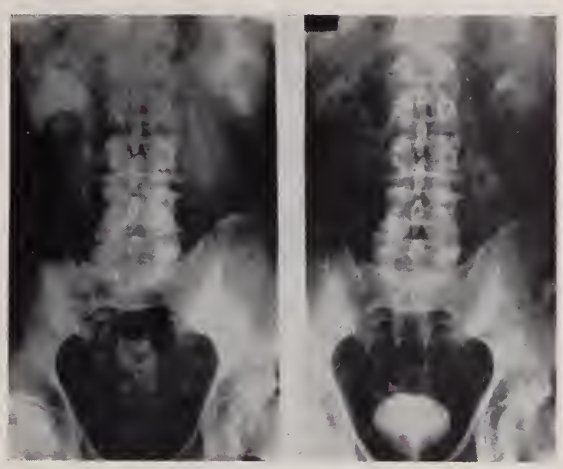


Figure 2. Intravenous urogram of a case of prostatic obstruction; left showing bilateral hydronephrosis and hydroureter; right, restoration to normal after relief of prostatic obstruction by transurethral resection.



Figure 3. Voiding cysto-urethrogram of 6 year old girl with recurrent bladder infection and enuresis. This is taken to indicate distal urethral stenosis.

obstructions lower in the urethra, such as B, C, or D as shown in Fig. 1. Another example is shown in Figs. 4, 5, and 6. They represent a 16 year old girl, who had always voided with difficulty. The left kidney, pyonephrotic, had been removed. Finally complete retention occurred. The intravenous urogram, Fig. 4, shows bilateral ureteral dilatation (the left ureter

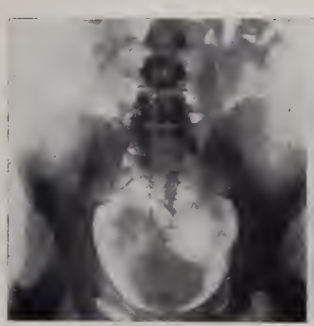


Figure 4. Intravenous urogram of 16 year old girl with severe urinary tract infection and complete retention of urine. The left kidney has been removed.



Figure 5. Same case. Cystogram showing marked dilatation of proximal half of urethra.



Figure 6. Same case. Post-voiding film after removal of urethral valve by Young punch, showing complete emptying of bladder. Urine now sterile.

having filled by reflux), trabeculation, cellules, and marked dilatation of the proximal half of the urethra (Fig. 5). Very radical dilatation of the urethra produced no benefit. The urine was purulent and heavily infected. Finally a Young punch was inserted, and a few small bits of inflamed, edematous valvular folds were removed from the mid-portion of the urethra. In a few days the patient was voiding freely, emptying her bladder completely, as seen in the post-evacuation bladder film, (Fig. 6), and the urine had become clear and sterile without benefit of antibiotics, as this took place in 1936 before any of our present-day antibiotics had ever been heard of.

Divergent Trends

The general trend, therefore, of urologic advancement has been to disclose more and more obscure obstructions, and thus bring more and more urinary tract infections into the group subject to radical and permanent cure, and to restrict further and further the group of the so-called "non-obstructive" infections.

Many non-urologists have taken a very different trend. In their anxiety to avoid catheterization, internists began taking quantitative cultures of "midstream" or "clean catch" urine, not only from males, but also from females. If great care is exercised to cleanse the glans and fossa navicularis a "mid-stream" or "second glass" specimen from a male is reliable for culture. However, the extreme variations of the form of the parts, and of the distribution, quantity and length of hair of the female external genitalia make such specimens from females quite unreliable. Kunin and Paquin in a study of 3500 school children using "clean catch" specimens, found 50 percent of false positives. Moreover, since a colony count of under 10^5 per milliliter, or 100,000 indiviual organisms per cubic centimeter, is regarded as negative, many latent or indolent infections may not be detected by this method. If the "clean catch" specimen is sterile, catheterization may not be necessary, but many urologists prefer to obtain a specimen from a female patient with a sterile catheter after careful cleansing of the vulva, centrifugalizing 15 cc of it, spreading the sediment on a slide, staining it, and examining it with the oil immersion lens. Such a preparation is seen in Fig. 7, showing that small numbers of bacteria can easily be demonstrated, even in the absence of any leucocytes. If bacteria are present, therapeutic procedures can be begun at once, and if they are absent a few doses of a sulfonamide or other antibiotic drug will prevent infection. How this method compares with the quantitative culture method is shown in Fig. 8, a table prepared by Jay Sanford and his coworkers. Bacteria were easily demonstrated in the smears of every case with more than 10,000 colonies per c.c. in the "clean catch" cultures, but in 11 cases with less than 10,000 colonies, considered according to this technique as negative, bacteria were seen in the smears. Thus infected cases in a latent or indolent stage may be missed by the quantitative culture method.

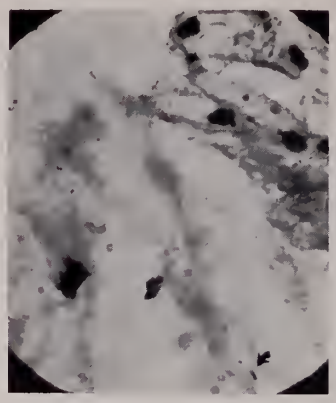


Figure 7. Stained smear of centrifugalized sediment of 15 c.c. urine, showing a few bacteria and no leucocytes.

CULTURE		BACTERIA IN SUS				WBC		
Cases	Colonies	0	rare	1+ 2+	3+ 4+	0	1-10	10+
10	0	10	0	0	0	9	0	0
34	1-1000	28	4	2	0	29	4	1
18	1,000 10,000	13	2	3	0	15	2	1
91	10,000+	0	0	26	25	13	41	27

Figure 8. Table showing comparison of stained-smear technique with quantitative culture. Note that bacteria are demonstrated by smear in 11 cases pronounced normal (uninfected) by the quantitative culture method.

This stained smear method has many advantages—it is rapid, taking only 5 - 7 minutes, it is inexpensive, it gives few if any false positives, and it appears that it avoids a good many false negatives. It is therefore very suitable for general use in physicians' offices.

At the Jefferson Medical College we have endeavored to improve our knowledge of the normal and abnormal physiology of the upper

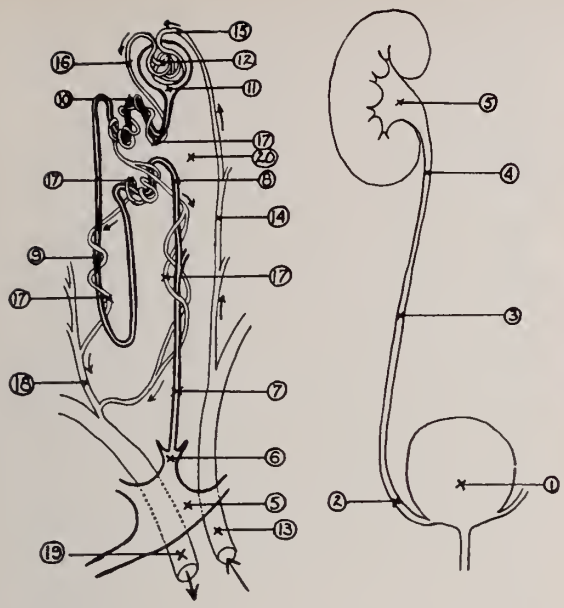


Figure 9. Diagram showing points in urinary tract where intraluminal pressures are very important for proper transport and evacuation of urine.

urinary tract, particularly to detect occult obstructions not detected by ordinary means.

All parts of the urinary tract surrounded by smooth muscle (pelvis, ureter and bladder) react to obstruction by contracting more strongly, with ultimate muscular hypertrophy, thus creating increased pressure to force the urine through the obstructed area. (Fig. 9) shows diagrammatically the different points in the urinary tract at which intra-luminal pressures are of the greatest importance for normal function. Roentgenographic evidence of obstruction is mostly in the nature of evidence of dilatation. This cannot occur until after increased pressures have failed to propel the urine normally; in other words, until decompensation has set in. Determination of intraluminal pressures, therefore, should disclose obstructions at an earlier stage than they can be demonstrated in roentgenograms.

Pressure Studies

We have established Kiil's method of determining intrapelvic and intraureteral pressures as practicable for routine use in human beings in a urologic clinic. Kiil placed very small catheters in the pelves and ureters, of such size that they did not interfere with normal peristalsis and normal transport of urine from kidney to bladder. They served only to transmit the pelvic and ureteral pressures to transducers or strain gauges, where the pressures were translated into electric currents which, when amplified, actuated writing galvanometers to produce a continuous graph of the pressures within the various parts of the urinary tract. (Fig. 10, 11, 12, 13.)



Figure 10. 100 cm. cardiac catheters (No. 4 or 5) used in pressure studies, and pan-endoscope with which they are inserted.

This method has proved acceptable, and a large number of cases has been examined. We have shown that advanced and serious disturbances of urinary transport can occur before any roentgenographic evidence of disease is present, so that our diagnostic means are more delicate than ever before.

To illustrate the advantages of this method I shall cite a few cases.

The first is that of L.W., a 40 year old woman with persistent pain in the right kidney. Fig. 14 shows an intravenous urogram which appears to be within normal limits, Fig. 15 shows pressure graphs from both sides, taken at levels varying from 5 cm to 28 cm. above the ureterovesical junction. At 28 cm. the eye of the catheter is in the kidney pelvis. On the left side contraction pressures in the upper ureter are low. In the lower ureter they are high, about 50 cm H_2O above resting pres-



Figure 11. Stratham strain gauges to which the catheters are attached.



Figure 12. Gilson minipolygraph (direct-writing oscillograph) with which pressures are recorded.

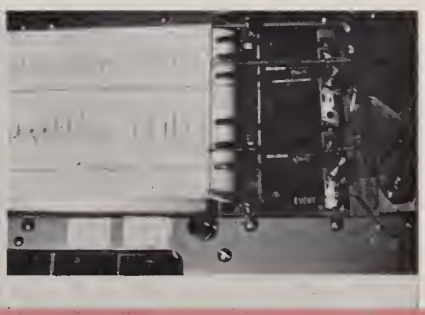


Figure 13. Typical graph of intraureteral pressures (left and right) being recorded.



Figure 14. Intravenous urogram, diagnosed as normal, of 40 year old woman (L.W.)

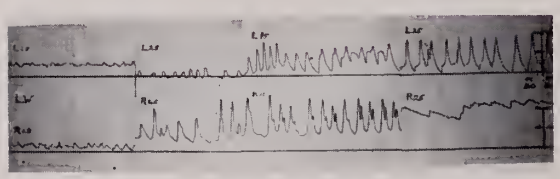


Figure 15. Pressure graph of patient shown in Fig. 14; pressures taken at different levels. See description in text.

sure, but the resting pressure does not rise, indicating that the ureter, by increasing its contraction pressures, is emptying itself and is therefore in a state of compensation. On the right side the contraction waves are also powerful in the middle and lower segments of the ureter, but the resting pressure rises progressively, showing that the ureter is unable to empty itself at each peristaltic wave. At 5 cm. from the bladder the resting pressure equals the contraction pressure, practically abolishing peristalsis. Here is a lower ureteral obstruction with complete lack of roentgenographis demonstration. The presence of a No. 5 catheter in the ureter has undoubtedly added to the lower ureteral obstruction, as shown in Fig. 16, thus bringing about ureteral decompensation and being therefore of marked diagnostic value.

The second case to be cited is that of A.B. Three important facts are demonstrated in this one case, namely, first, the effect of operation upon the functional ability of the ureter, second, the effect on ureteral function of elevation of bladder pressure, and third, the retention of contractile power of a ureter after 21 years of dormancy following the removal of its kidney.

(Fig. 17) The obstruction in the upper left ureter was a congenital narrowing 12 cm long. The ureter was incised for that distance, and intubated with a No. 14 T tube for four weeks (Fig. 18). Convalescence was uncomplicated. The right kidney, reduced to a calculous pyonephrosis, had to be removed immediately after the operation on the left side. During the ensuing twenty-one years the patient has remained in perfect health, with clear sterile urine, normal P.S.P. excretion and blood urea

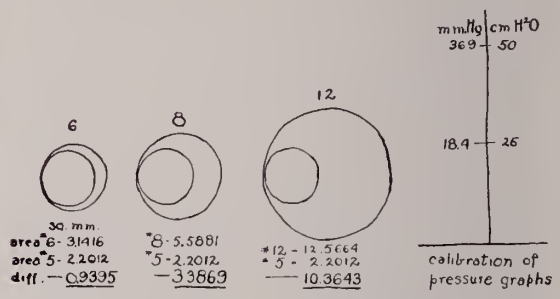


Figure 16. Diagram showing extent to which a No. 5 catheter diminishes the lumen of ureters of varying sizes. In a No. 12 ureter, the effect in negligible, but in a No. 6 ureter, obstruction is greatly increased.



Figure 17. Intravenous urogram of 28 year old woman (A.B.) Calculopyonephrosis on right, upper ureteral congenital narrowing 12 cm. long on left, with hydronephrosis.

nitrogen, and normal appearing intravenous urogram. (Fig. 19). The area which had been operated upon is that part of the ureter lying between 16 and 28 cm above the bladder. The pressure graph (Fig. 20) shows that in this region, the peristaltic waves are of minimum amplitude, while at 15 cm. the peristaltic pressure graph becomes quite normal and continues so to the bladder. In spite of the abnormal character of the peristalsis in the reconstructed part of the ureter, the intra-pelvic pressure is within normal limits, and the transport of urine appears to be quite normal and satisfactory, even after nearly a quarter of a century.

It is noted that ureteral contraction pressures measured 15 cm from the bladder were approximately 40 mm Hg above ureteral resting

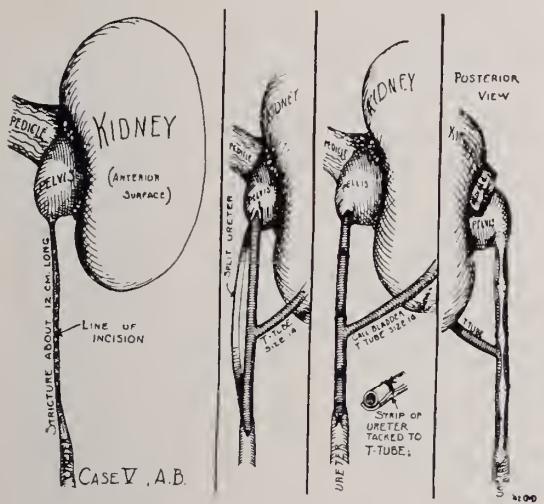


Figure 18. Same case. Diagram showing operation of intubated ureterotomy performed on left ureter 21 years ago. The right kidney was removed a short time later. (A.B.)



Figure 19. Intravenous urogram (same case) made 17 years after operation, showing normal left pelvis and ureter. (A.B.)

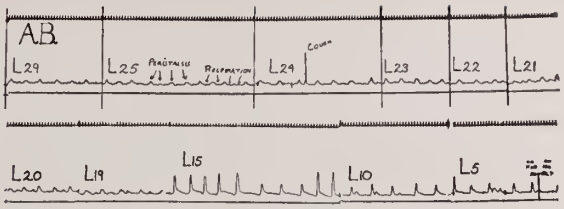


Figure 20. Same case. Pressure graph showing lower peristaltic pressure in operated portion of ureter. See description in text (A.B.).

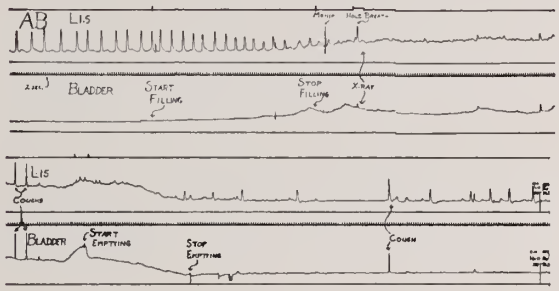


Figure 21. Same case. Pressure graph showing effect of increased intravesical pressure on ureteral function. See description in text. (A.B.).



Figure 22. Same case. Cystogram made at time of maximum intravesical pressure, showing no ureteral reflux. (A.B.).

pressure. As the bladder pressure was raised to 40 mm Hg the ureteral resting pressure rose and ureteral peristalsis was practically abolished (Fig. 21). Subsequent changes in bladder pressure were not accompanied by simultaneous changes in ureteral pressure, indicating that reflux had not occurred. Also, roentgenograms taken at this time showed no reflux (Fig. 22). The rise in ureteral resting pressure must therefore, have been due to the force of ureteral peristalsis acting on the urine coming down the ureter, which was unable to escape into the bladder. Reduction of the intravesical pressure was followed by a gradual drop in ureteral resting pressure and return of peristalsis.

On the right side, observations were made

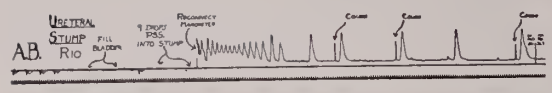


Figure 23. Same case. Pressure graph of right ureter and bladder. Ureter completely inactive until fluid is injected, then normal peristaltic response. (A.B.).

on the ureteral stump which was not dilated, and which presumably had not functioned for twenty-one years. (Fig. 23) As the bladder was filled, no change occurred in the intra-ureteral pressure at 10 cm from the bladder, so that there was no evidence of reflux or ureteral activity. However, when nine drops of physiological salt solution was injected into the ureter, very active rhythmic contractions of good amplitude began. The amplitude progressively diminished and contractions finally ceased, due presumably to partial emptying of the ureter. The ureteral muscle continued quite irritable, however as each time the patient coughed, a single ureteral contraction occurred about four seconds later.

The third case (I.B.) demonstrates that a blind ureter subjected to reflux may become greatly dilated and undergo loss of its peristaltic ability. The right kidney and the septum from a bilocular bladder had been removed years before. Pain in the right lower quadrant persisted, and was shown to arise in the greatly dilated right ureteral stump. Intravenous urography demonstrated "low pressure" reflux on the right (Fig. 24). A pressure graph with one catheter in the ureter, another in the bladder (Fig. 25) proved that the pressures in the two were identical at all times, with no evidence of any contractile power whatever in the ureter.

Ureteral Reflux

Some of these observations have, it seems to us, a direct bearing on the question of the

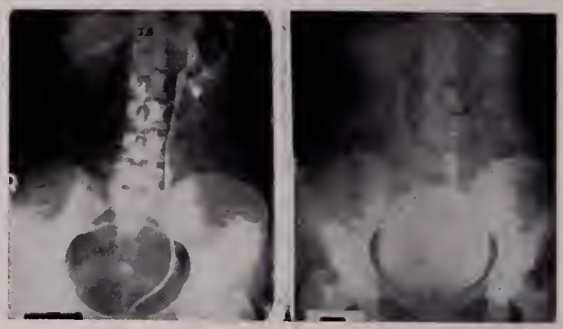


Figure 24. Intravenous urogram of 27 year old woman, with pain in right loin, (I.B.). Right kidney previously removed. Reflux into dilated right ureter.

etiology of ureteral reflux, now so widely discussed. To the present time we have not seen, either in our pressure studies, nor in our clinical practice any case of low pressure reflux in an undilated ureter. Ureteral dilation, often present due to lower tract obstruction, usually disappears after the obstruction is relieved. In any case where reflux is discovered it is impossible to investigate what occurred at any previous time, and we are therefore totally unable to say whether low pressure reflux is due to some congenital abnormality of the uretero-vesical junction, or whether it is a manifestation of ureteral decompensation resulting from lower tract obstruction with chronically high intravesical pressures. To solve this question categorically we believe that we will have to have, first, apparatus to make simultaneous recordings of pressure graphs and cinefluoroscopic images of bladder and ureter, and, second, careful and thoroughgoing studies of the long-term reversibility of ureteral dilatation and reflux after discovery and adequate surgical relief of lower tract obstructions. Animal experiments with carefully controlled lower tract obstructions may also help.

For the future, it seems that these new modalities and new concepts will disclose very large numbers of abnormalities hitherto

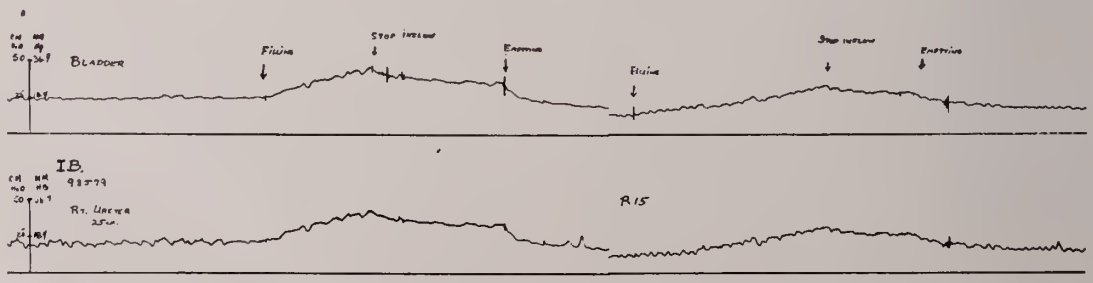


Figure 25. Same case. Pressure graph showing pressures identical in right ureter and in bladder at all times. (I.B.).

neglected, and practically all subject to correction by dilatation or other surgical means. We reject most categorically the contention, as stated by Edward Kass, that eighty percent of all cases of bacteriuria are incurable. The discovery and effective treatment of urinary tract abnormalities is essential for the elimination of infection from the tract. Particularly will this be possible and of the utmost value in the case of children. Here is a tremendous field for preventive urology, where, in time, much of adult urologic disease can be intercepted and prevented. This is truly an inspiring and stimulating outlook for those physicians who take part in it. May we trust that no one will frustrate or delay this fine forward step.

REFERENCES

Brewer, Surg., Gyn. and Obst., 2:485, 1906.

Cabot, H. and Crabtree, E.A.: *Non-Tuberculous Renal Infections,* Surg., Gyn. and Obst 23:495, 1916.

Sweet, J. E., and Stewart, L. F.: *The Ascending Infection of the Kidneys,* Surg., Gyn. and Obst., 18:460, 1914.

Davis, D. M., *On Infections of the Urinary Tract,* Archives of Internal Medicine, 112:6, 1963.

Kass. E. H., *Chemotherapeutic and Antibiotic Drugs in the Management of Infections of the Urinary Tract,* Amer. Jour. Med., 18:764, 1955.

Kass. E. H., *Pyelonephritis and Bacteriuria,* Annals of Int. Med., 56:45, 1962.

Pawlowsky, J. M., Bloxdorf, J. W. and Kimmelstiel, P., New Engl. Jour. Med., 268:965, 1963.

Lich, R., Jr., *Vesicourethrography,* Jour. Urol., 85:396, 1961.

Lyon, R. P. and Smith, D. R., *The Distal Urethral Stenosis,* Trans. Amer. Assn. Gen.-Urin. Surg., 54:150, 1962.

Kunin, C. M., Southall, I., and Paquin, A. J., *Epidemiology of Urinary Tract Infections,* New Engl. Jour. Med., 263:817, 1960.

Sanford, J. P., et al, Amer. Jour. Med., 20:88, 1956.

Kiil, F., *The Function of the Ureter and Renal Pelvis,* W. B. Saunders & Co., Philadelphia, 1957.

Davis, D. M., *The Hydrodynamics of the Upper Urinary Tract* (Urodynamics), Ann. Surg., 140:839, 1954.

Davis, D. D. and Zimskind, P. D., *Progress in Urodynamics,* Trans. Amer. Assn. Gen.-Urin. Surg., 53:60, 1961.

Davis, D. M., Zimskind, P. D. and Paquet, J-P., *Studies in Urodynamics, New Light on Ureteral Function,* Jour. Urol., 90:150, 1963.

Davis, D. M. and Zimskind, P. D., *Pathologic Types of Ureteral Pressure Graphs with Remarks on Their Relation to Lower Tract Obstruction,* Jour. Urol. 90:677, 1963.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisaole and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

SPECIAL ARTICLES

On Succeeding in Medicine*

HARLAN ENGLISH, M.D.**

Danville, Illinois

MINDFUL of the good Quaker admonition "no one should speak unless he can improve the silence" let us visit with you for a while and try to improve the silence. Nearly everyone whether he be a student, truck driver, or a physician wants to succeed or be successful in his chosen or unchosen lot in life.

The house of medicine has many rooms in it. There is a place for anyone to be successful in medicine if he will just work. He can be successful as a teacher, a successful researcher, a successful administrator, or even a successful swivel chair doctor. A few ordinary practitioners like myself have reasonable success.

It is eloquently true that good doctors are always hard to find. My observation is that we are in a short supply of Orthopedists, Eye physicians, and Ear, Nose and Throat physicians. Surgeons are in oversupply. O.B. and Gyne doctors appear to be about adequate. General physicians are becoming fewer and fewer and in the rural portions of America are becoming more and more valuable.

The first recipe I can give you is "make it your business to know yourself." This is one of the most difficult lessons you will ever learn. It has been my experience that people who can't manage themselves and their personal affairs are not very good advisors in the area of health affairs for their patients.

There are basically two kinds of education. One was given you while you were going through college and through medical school. Your M.D. degree will indicate that. In medical school some want to learn the "tricks of the trade." Others want to get all the scientific information possible. Medicine can't surrender to the pure technical training area or soon we will be a colony of sterile ants.

To me the second kind of education is the most valuable. It is the one that you give your self because every day you have to work with and manage yourself.

The second recipe for success is what I would like to call character. I think of character as what God and the angels know about each one of us. Character is molded in each of us in the crucible of our work, by our habits, and by the silent influences of able teachers and colleagues on us every day of our lives.

You probably all know that more money and effort has been spent on making you M.D.'s than is spent on any other group of citizens. So the third recipe I give you, you must be generous.

Added to generosity will be discretion. Your discretion will be tested by thousands of secrets and I would not be telling my wife about patient's illnesses. You will have to develop tact because it will be tried by thousands of embarrassments.

The fourth recipe I would give you will be the courage of your convictions and confidence in your area of work. You will find cheerfulness and courage in lots of your patients.

The fifth recipe I would give you would be faith. Faith is the most wonderful thing in life. You are going to see lots of faith in the faces of your patients. You, yourself, will need lots of guidance from that *inner light* in many of your own trying situations. In my own experience, faith just can't be overdone.

Despite all of our scientific progress in all of your practices you are going to see many people die. Death is inevitable for all of us. I happen to be one who likes to heed the admonition of Dr. Fischel of the Cancer Hospital in St. Louis. He used to say, "Gentlemen, it is our duty to

*Presented on Senior Day at University of Louisville School of Medicine on March 16, 1964.

**President of the Illinois State Medical Association.

help people to live, it is also our duty to help people to die gracefully." I am one who feels that it is not legally required that everyone die in the hospital with tubes in all the orifices, solutions running in all of the veins and a perfect laboratory electrolyte balance. To me John Milton's advice is as good as when he gave it. "They also serve who only stand and wait."

Osler, the greatest clinician of them all, and others have noted that an important secret to many people's success is their failure to use alcohol until they are past 50 years of age. Clear heads and kind hearts succeed in medicine, just as they succeed in any other way of life. You had best respect older doctor's consultations and advice because experience is a wonderful teacher.

The seventh recipe I would give you is—"take time out for politics." You just can't afford not to be interested in electing good men to operate your government in the court house, the state house, or in Washington. These men are going to spend between ¼ and ½ of every dollar you will ever make. If you take no interest in your government, you are just like a drowning man who the third time says he is not interested in learning how to swim.

You had best be honest in your tax returns because the revenue service will get you, either while you are alive or ruin your estate when you are dead with fraud charges and penalties.

Politicians are constantly telling you and me that ignorance of the law is no excuse for its violation. I contend that you and I must tell the politicians and our representatives in Washington that their ignorance of our fine medical care system, despite its minimal defects, is no excuse for them passing laws harmful to all of their patients and all of us.

The ninth recipe I would give you is, make people understand. Talk to your patients and to others until they do understand. Spending such time will pay you handsome dividends and pay the patients handsome dividends.

In the operation of your and my American Medical Association some groups try mass assaults on our sections, on our various councils and on the House of Delegates Reference Committees. These tactics have failed and will fail because volumes of noise and masses of bodies just don't take the place of understanding.

As you go through life, especially in the practice of medicine, there are two things you will always meet; and you should pay them no mind. They are abuse and flattery. Abuse can't harm you, and flattery can't help you. My last recipe would be summerized in one word—work. The only place you will find success preceding work is in Webster's Dictionary. You will never find it in life. Your own values, spiritual, moral, and economic are going to depend on how well you serve. You can demonstrate the 3 L's of Life by "loving your family," "lifting your community," and "leading your patients."

When I started in the practice an old successful doctor gave me a prescription which I will pass on to you. He said:

Take 3 ounces of "the breadth of vision"
Add 8 cc of "I am my brother's keeper"
Put in a dash of "human kindness"
Then drop in 8 drops of "the oil of graciousness"
Take a teaspoonful or more each day, as you need it,
And when you pass on no one can say
"He lived for himself alone."

Success as I see it is 99% mental attitude. It is compounded of character, self-education, courage, cheerfulness, competence, faith, honesty, humility, patience and work. Don't spend your life sitting in the thick of thin things.

EDITORIALS

It Ranks With the Best

THE substantial position enjoyed by the Annual Meeting of our Association was again demonstrated in a recent national survey of the annual meetings of all state medical associations conducted by the Medical Society Executives Association. The survey was made in an effort to identify trends, spot weaknesses, and learn what makes the better operations tick.

Only about a third of the states reported increased attendance at their annual meetings. The attendance records of the KSMA Annual Meetings over the past 15 years show that our attendance has almost tripled. While some states register only 20 to 25 per cent of their membership at their annual meetings, Kentucky now has an average registration of between 45 and 49 per cent of its membership. Our record ranks with the very best.

There appears to be some relationship between attendance and the type of program presented at the annual meeting. Those organizations which emphasize the scientific aspects of the program and present the strongest scientific material appear to have better attendance. Those who design the program for KSMA do not try to compete with television and the night clubs.

Success begets success, but there is a reason. Our success is due to the fact that we have been regularly blessed with program committees that have regularly produced excellent scientific programs. A review of the program material printed in the Annual Meeting Section of this journal for our 1964 meeting conclusively demonstrates how fortunate we are to have committees of this caliber.

An international flavor is added with the presentation of a Trans-Atlantic Clinical Conference during which our physicians work with our British colleagues. Added depth and diversification are obtained with the participation of 14 specialty groups whose meetings are open to all who care to attend.

Other features of our 1964 meeting make it particularly attractive. We will have the largest number of scientific exhibits we've had since the Centennial meeting 13 years ago, and the largest technical exhibit in the history of the Association. The President's Luncheon will be unusually attractive this year. You will be interested in watching the Association's business transacted at the important meetings of the House of Delegates.

For the first time in any state association meeting, so far as we know, phyisicians will be offered a Limited Clinical Laboratory Health Evaluation by the Kentucky Society of Pathologists. And, again for the first time, there will be a message center. This is being sponsored by the telephone company without cost to this Association.

The time we spend at our Annual Meeting is a highly profitable interlude in our professional life. It is always refreshing to visit with friends and colleagues. It enables us to return to our practice better equipped to serve our patients. You will not want to miss this enriching experience this year.

HENRY B. ASMAN, M.D.

Remember The Southern

THE Southern Medical Association will meet this year in Memphis, Tennessee November the 16th to 19th. For many of us it has perhaps been a long time since we visited the ancient and colorful shipping port on the Mississippi River and we may be Greatly surprised and perhaps lost in the modern Metropolis that now is Memphis. Annually Kentucky physicians attend the Southern in comparitively large numbers. This year, since it meets on our next door neighbors' front porch, we should be there en masse to enjoy the activities and help our neighbor host the convention.

The Southern presents in its program something of vital interest to every physician of whatever training or interest. It offers as great a variety of scientific material as does the American Medical Association at it meetings. The convention should be contrasted with the AMA rather than compared with it. Unwieldy crowds arc not there. Diversity of interest and entertainment is more social than political. Outside recreation is more eaily accessible and the ladies have a picnic. The hospitality of the wives of the host city has long been a distinguishing feature of the Southern.

Kentucky has always participated in the affairs of the Southern Medical Association in an unusually pleasant and effective manner. During the past thirty years five Kentucky physicians have been presidents—Drs. Able, McCormack, Henderson, Ryan and McCarty. Since the whole area of the Southern comprises only seventeen states it is apparent that our participation in the affairs of the organization has been proportionately very large. Dr. J. Duffy Hancock at present is our distinguished representative on the Board of Trustees and in this we should have a sense of pride.

A visit to Memphis in the late fall is always an unforgetable experience. Don't miss it.

SAM A. OVERSTREET, M.D.

As Others See Us

THE Medical Tribune of July 15, 1964 carried a rather provocative editorial by Mr. Sargent Shriver entitled "Doctors, Peace Corps, and Poverty." He wrote in part:

We can trace the civilization of medicine in this country back to the famous Flexner report, 50 years ago. The impact of this report brought a new focus on the vital importance of science in what must be a scientific profession, as well as a human one. Since then, we have witnessed a startling revolution in medical standards and technology.

But at the same time we have lost something of our human contacts. Doctors have had to specialize more and more. Their training has become more complicated and time-consuming.

Science, research, and specialization give Americans the best-trained doctors in the world. But these aspects of medicine also leave us, your patients, a little bewildered. We want you to continue treating us as people; but, frankly, we grow skeptical as specialization claims more young doctors who might have become general practitioners 25 years ago.

Perhaps the demands of technology make this situation inevitable. But, like most laymen, I would like to see science humanized, and I have two proposals which might fulfill this hope.

The proposals are simply: Why not join the Peace Corps? Why not consider serving in the War against Poverty?

It seems pointless to bewail the passing of the general practitioner and much of the bewailing is purely sentimental blubber. The general practitioner has not passed from the American scene and will not pass in the foreseeable future. Nobody wants him to become extinct and there is not the remotest likehood that he will. He performs a most valuable service in American medicine. A good and well trained physician whether in general practice or in a limited field is of equal value.

It is likewise unrealistic to decry increased specialization. The remarkable progress American medicine has made in the last two generations has been mostly due to the fact that more

physicians have been willing to take time and effort required to learn more in greater depth about some special phase of practice to which their interest is attracted. The increased number of better-trained men has meant that they no longer confine their practice to the city, but with the establishment of hospitals and better medical facilities in smaller towns they have carried a higher type of practice to the more remote communities. Many smaller towns in Kentucky and throughout the United States now have available services of highly trained men in special branches of medicine. A generation ago a patient had to travel at great expense and inconvenience long distances to obtain the type of service that is now available to him in his own town.

It is reasonable to presume that the writer would require for himself and his family the services of the most highly trained physicians available for any illness affecting them. It is gratifying to know that now such services are available to the vast majority of American families wherever they may reside.

The suggestions contained in this editorial that American physicians have an obligation to extend their skill and services to the ends of the earth as a measure of friendship and neighborliness is, of course, commendable and appropriate. Visitors in South America, Africa and Asia have returned with the report that the work of the Peace Corps in these areas seems to be a stronger factor for the promotion of peace and brotherhood among nations than most of our monetary help or diplomatic negotations.

A great number of physicians all over the United States including some of our very best trained men in Kentucky have participated in such activities abroad with the Peace Corps, Projects Hope and Medico, and with our medical missions. Such activity certainly can and should be extended; but we need to remember that physicians have already participated largely in the very type of foreign aid advocated by Mr. Shriver.

Poverty and the medically underprivileged we have with us everywhere. With or without government aid or subsidy these people have available to them the highest type of medical care the world has ever known. It is provided in their own community by the general practitioners and by the highly trained specialists alike. Of course this service must be improved and made more accessable to those who need it most.

In our own state the migratory worker has not constituted so much of a problem but whenever and wherever he has medical needs they have received the same attention given other more stable residents of the community. In areas where great numbers of these transients are employed it is impossible now to say what means can be best provided for their adequate medical care. It is reasonable to presume, however, that the practicing physician will contribute his part.

SAM A. OVERSTREET, M.D.

Meet Your Friends

at the KSMA Annual Meeting

September 29 - October 1



The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

In Diverticulosis and Diverticulitis...

METAMUCIL® brand of psyllium hydrophilic mucilloid

"Diverticulosis ... a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

"Diverticulitis Mild, chronic symptoms of diverticulitis, such as diarrhea or flatulence also are treated[1] by low-roughage diet, adequate fluid intake and Metamucil...."

Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

Research in the Service of Medicine



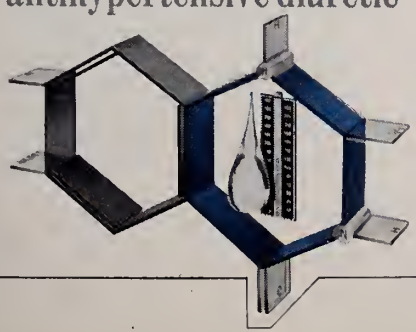
Just turned hypertensive

A 15 mm. Hg drop in diastolic pressure
would also suit her very well

For suitably gradual, physiologic
hypotensive treatment



HYDROMOX®
QUINETHAZONE·TABLETS
antihypertensive diuretic



HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle

0373-4

Index To Annual Meeting Section

KSMA Officers for 1963-64 679
District Trustees and Trustee Map 682
Delegates to the KSMA House 684
Reference Committee Activity 686
Annual Session Special Features 687
Official Call to Meeting 688
President's Luncheon Speaker 688
1964 Annual Meeting Program Summary 691
Complete Scientific Program of Annual Meeting 692
Scientific Exhibits 698
Technical Exhibits 699
Woman's Auxiliary Program 700

Annual Meeting Section

KSMA OFFICERS 1963 — 1964





Carlisle Morse, M.D.
Vice-President (Central)



Carl C. Cooper, M.D.
Vice-President (Eastern)



John Dickinson, M.D.
Vice-President (Western)

President-Elect

Delmas M. Clardy, M.D.

Hopkinsville

After serving for 18 years as a delegate to the Kentucky State Medical Association, Doctor Clardy was councilor for the Third Councilor District (now Trustee District) for six years. From 1958 until his selection as president-elect of KSMA, he served as treasurer of the Association.

A native of Stewart County, Tennessee, Doctor Clardy moved to Christian County as a small boy and attended schools there. By working 57 hours a week while attending Kentucky Wesleyan College, he earned enough to pay his entire expenses while there, as well as enough for his first year of medical school. In 1932, Doctor Clardy graduated from the University of Louisville School of Medicine.

After interning at St. Joseph's Hospital in Lexington, he started practice in Hopkinsville in 1934. At that time he was instrumental in starting the first department of surgery at Western State Hospital and has served as surgeon there since then. He is presently chief of surgery at Jennie Stuart Hospital in Hopkinsville and past president of the medical staff, consultant and surgeon for Kentucky Training School, and surgeon for the L & N and Illinois Central Railroads.

Active in KSMA since he started practice, Doctor Clardy was chairman of the Public Health Committee when it succeeded in getting a compulsory immunization law passed. He is a member of the Board of Trustees of the Rural Scholarship Fund and this year is co-chairman of the Council on Scientific Assembly.

Immediate past president of the Kentucky Surgical Society, he is a member of the Board of Directors of the Kentucky Physicians Mutual, a fellow of the American College of Surgeons, and a member of the Southeastern Surgical Congress. Doctor Clardy is a past president and former secretary of the Christian County Medical Society and was a member of the liaison committee for creation of the University of Kentucky Medical School.

A general surgeon, he served as First Lieutenant, Captain, and Major in the U.S. Army Medical Corps during World War II. He headed the surgical section of the 187th General Hospital in the European Theater of Operations.

His leadership in KSMA and medically related activities, his deep loyalty to his profession, and his personal integrity gave the House of Delegates confidence that he would live up to the high standards set by his predecessors and made him the logical choice for this high office.

VICE PRESIDENT, CENTRAL

Carlisle Morse, M.D., Louisville

Doctor Morse, a past chairman of the Board of Trustees of the Kentucky State Medical Association, was elected in 1956 as a Trustee (then Councilor) from the Fifth District, and served in that capacity until his election as a vice-president in 1963. A native of Caldwell County, he received his Doctor of Medicine degree from the University of Louisville in 1930. He is a past secretary and treasurer of the Jefferson County Medical Society and has served as Governor for Kentucky of the American Diabetes Association. Doctor Morse is a former chairman of the KSMA Diabetes Committee. He is an assistant clinical professor of medicine at U. of L.

VICE PRESIDENT, EASTERN

Carl C. Cooper, M.D., Bedford

Doctor Cooper, a graduate of the University of Louisville School of Medicine with an M.D. degree in 1952, is a general practitioner in Bedford. He served for two years as chairman of the KSMA Senior Day Committee and a member of the KSMA Council on Communications and Public Service. He is a past alternate delegate to the AMA and has served as KSMA's representative on the Kentucky Health Council. A director and past vice president of the Kentucky Academy of General Practice, he is vice chairman of the Trimble County Board of Education and past president of the Bedford Rotary Club.

VICE PRESIDENT, WESTERN

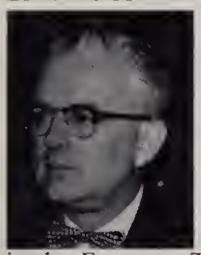
John Dickinson, M.D., Glasgow

A surgeon and a native of Barren County, Doctor Dickinson is a past president and a member of the Board of Directors of Kentucky Physicians Mutual, Incorporated (Blue Shield Plans of Kentucky), and is currently serving on the KSMA Insurance Review Board. A 1933 graduate of the University of Louisville School of Medicine, he served in the Medical Corps of the U.S. Army for 45 months during World War II and was on the surgical service of the 39th General Hospital in the Pacific Theatre of Operations. Doctor Dickinson is a Fellow of the American College of Surgeons, the Southeastern Surgical Congress, and the Kentucky Surgical Society, and is a former vice president of the latter.

KSMA Secretary and Treasurer

SECRETARY

Henry B. Asman, M.D., Louisville



Doctor Asman, a graduate of the University of Louisville Medical School in 1936, succeeded Wood-B. Troutman, M.D., as secretary in 1963. A former vice president of the KSMA (1961-62) and a past president of the Kentucky Division, American Cancer Society, Doctor Asman is a Fellow of the American College of Surgeons and the Southeastern Surgical Congress. He was a Lt. Colonel in the European Theater of the AUS serving from 1942 to 1946. A past president of the Ohio Valley Proctology Society, Doctor Asman limits his practice to Col-proctology. He is active in the Jefferson County Medical Society.

TREASURER

Keith P. Smith, M.D., Corbin



Elected treasurer in 1963 to replace president-elect Delmas Clardy, M.D., Doctor Smith has been active in KSMA activity for many years. He has served as a KSMA vice president and has been president and vice president of the Kentucky Academy of General Practice. A 1936 graduate of the University of Louisville School of Medicine, he has held numerous offices in his county medical society. During World War II, he served 42 months with the U.S. Air Force and was discharged with the rank of major in 1945. Doctor Smith is active in civic affairs in Corbin and is a Kiwanian.

KSMA Journal Editors

EDITOR

Sam A. Overstreet, M.D., Louisville



Doctor Overstreet, Centennial president of KSMA in 1950-51, has served as editor of the Journal for the past six years. Prior to that time he was scientific editorial editor. An internist, he is a 1923 graduate of the University of Louisville School of Medicine, and now serves on the faculty as clinical professor of medicine. He is a former speaker of the KSMA House of Delegates and a former governor of the Kentucky Chapter, American College of Physicians. Doctor Overstreet is a member of the Kentucky State Board of Health. He was president of the Jefferson County Medical Society in 1947.

ASSOCIATE EDITOR

Walter S. Coe, M.D., Louisville



After serving as book review editor of The Journal for several years, Doctor Coe was named associate editor in 1962. A 1943 graduate of the University of Louisville, he is now an associate clinical professor of medicine at U. of L. Currently president of the Kentucky Society of Internal Medicine, he is a past president of the Louisville and Jefferson County Heart Association and director of the Kentucky Heart Association. Doctor Coe also serves as chairman of the KSMA Council on Medical Education and Hospitals. He is president of the U. of L. Medical Alumni Association.

AMA Delegates

Wyatt Norvell, M.D., New Castle



Doctor Norvell, a former chairman of the Board of Trustees of KSMA and a past vice president (Eastern) of the Association, was elected delegate to the AMA in 1962. For several years he was Trustee from the Seventh KSMA Trustee District and has been chairman of the Committee on Rural Health; he is a member of the KSMA Memorials Commission. Doctor Norvell is a former director of the Kentucky Academy of General Practice and a former president of the Henry County Medical Society. He graduated in 1941 from the University of Louisville School of Medicine.

J. Thomas Giannini, M.D., Louisville



Doctor Giannini, who limits his practice to plastic and reconstructive surgery, graduated from the University of Louisville School of Medicine in 1939-42. He was in the U. S. Navy Medical Corps as a Captain from 1942 to 1954. He is a fellow of the American Society of Plastic and Reconstructive Surgeons. He has served KSMA as alternate delegate to the AMA and as chairman of the Scientific Exhibits Committee, as well as a delegate to KSMA from Jefferson County Medical Society.

AMA Delegate

John C. Quertermous, M.D., Murray



After graduating from the University of Louisville Medical School in 1942, Doctor Quertermous served in the Army from June, 1943 to November, 1946. He started private practice in internal medicine in Muray. Doctor Quertermous has served KSMA as a member of its Committee on Aging, Committee on Postgraduate Medical Education, Legislative Council, and as alternate delegate to the AMA. He is a president of the Calloway County Medical Society and a past president of the Murray Rotary Club. In 1960-61 he was on the Governor's Citizen's Committee on Problems of Aging.

New Trustees

FIFTH DISTRICT

Alfred O. Miller, M.D., Louisville

A graduate of the University of Louisville School of Medicine in 1939, Doctor Miller was vice president (central) of KSMA in 1962-63. Doctor Miller has engaged in the private practice of radiology in Louisville since 1948 and is an assistant professor of radiology at the University of Louisville School of Medicine. He has served as a past counselor for Kentucky for the Radiological Society of North America and chairman of its Radiologist-Manufacturers Committee. A diplomate of the American Board of Radiology, he is a member of the American Roentgen Ray Society. He is a past counselor for Kentucky of the American College of Radiology.

SIXTH DISTRICT

Rex E. Hayes, M.D., Glasgow

A former vice president of the KSMA (1959-60), Doctor Hayes graduated from the University of Louisville School of Medicine in 1933. Following his graduation he took a rotating internship and two years residency in medicine at Louisville General Hospital. He entered private practice in Glasgow in 1936 and has practiced there ever since, except for four years in the U. S. medical corps. Doctor Hayes is on the active staff of the T. J. Samson Community Hospital and has served as chairman of the Barren County Health Department. He is a native of Monroe County.

EIGHTH DISTRICT

W. Donald Janney, M.D., Covington

Chairman of the KSMA Council on Allied Professions and Related Groups, Doctor Janney received his M.D. degree from the University of Wisconsin in 1951. A diplomate of the American Board of Radiology, he interned in St. Paul, Minn., and took his residency in radiology at the Indiana University Medical Center. He has been in private practice since 1957. Doctor Janney received his board certification in radiology in 1957. He served in the USAF as a flight surgeon and medical officer in 1952-54 with the rank of captain. Doctor Janney is a native of Wisconsin.

FIFTEENTH DISTRICT

Robert E. Pennington, M.D., London

In 1961-62, Doctor Pennington served KSMA as vice president representing the eastern portion of the state. He received his medical training at the University of Pennsylvania, graduating in 1936. A surgeon, Doctor Pennington took residency training in pathology at Western Reserve University and surgical training at the Mayo Foundation, Rochester, Minn. He served four years in the army and he was awarded the Bronze Star for meritoriuous service. He has been secretary of the Laurel County Medical Society and is a member of the American College of Surgeons and the Southeastern Surgical Congress.

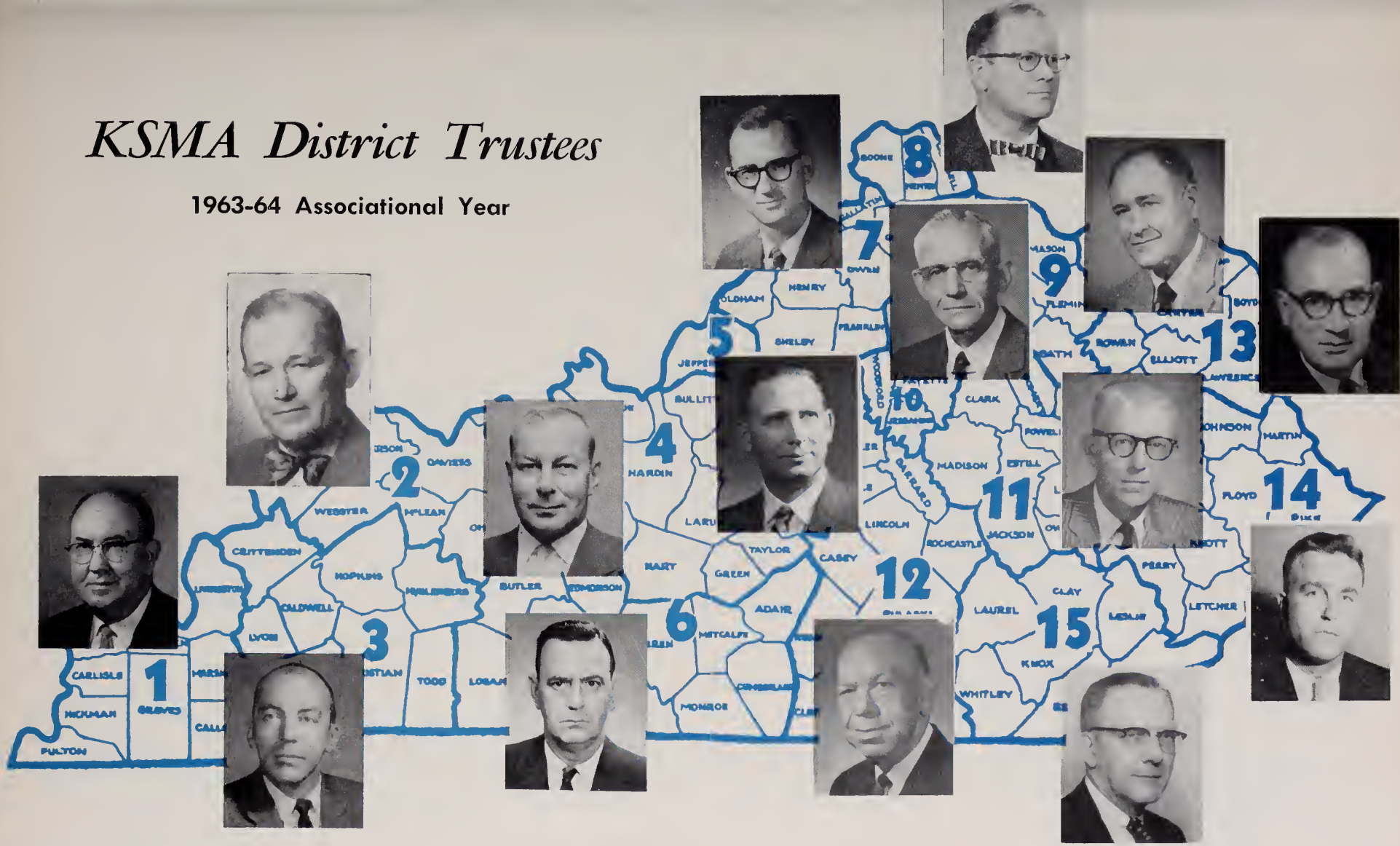
Election of Trustees

Five KSMA District Trustees will be elected by the House of Delegates at its second session on Wednesday, September 30. Immediately after the first session of the House on September 28, nominations will be made at a caucus of the delegates from each district. At the close of the first scientific session on Tuesday, September 29, the committee will report its nominees. Further nominations may be made from the floor at the second meeting of the House on September 30. Districts electing new trustees are: **Second District** (incumbent, Howell J. Davis, M.D., Owensboro), **Seventh District** (incumbent, Donald Chatham, M.D., Shelbyville), **Ninth District** (incumbent, Mitchel B. Denham, M.D., Maysville), **Tenth District** (incumbent Douglas E. Scott, M.D., Lexington), **Thirteenth District** (incumbent, Clyde C. Sparks, M.D., Ashland). All the present trustees are eligible for re-election. Biographical information on trustees elected in 1963 appears above.

see map on following page

KSMA District Trustees

1963-64 Associational Year



1. O. LEON HIGDON, Paducah
2. HOWELL J. DAVIS, Owensboro
3. GABE A. PAYNE, JR.*, Hopkinsville
4. DIXIE E. SNIDER*, Springfield
5. ALFRED O. MILLER, Louisville
6. REX E. HAYES, Glasgow
7. DONALD CHATHAM, Shelbyville
8. W. DONALD JANNEY, Covington
9. MITCHEL B. DENHAM*, Maysville
10. DOUGLAS E. SCOTT †, Lexington
11. HUBERT C. JONES, Berea
12. THOMAS O. MEREDITH, Harrodsburg
13. CLYDE C. SPARKS, Ashland
14. WILLIAM C. HAMBLEY, Pikeville
15. ROBERT C. PENNINGTON, London

†*Chairman of the Board*
**Member of the Executive Committee*

Officers of the KSMA House of Delegates

SPEAKER

Garnett J. Sweeney, M.D., Liberty



After serving since 1959 as vice-speaker of the House of Delegates, Doctor Sweeney was named speaker in 1962. Before becoming vice speaker, he was chairman of the KSMA Council (now the Board of Trustees). At that time he had served two terms as councilor from the 12th Councilor District. Doctor Sweeney graduated in 1939 from the University of Louisville School of Medicine. He was 1954 president of the Kentucky Academy of General Practice. He is a member of the Board of Directors of the Kentucky Physicians Mutual Inc. and a member of the KSMA Advisory Commission to Blue Shield.

VICE SPEAKER

George F. Brockman, M.D., Greenville



Doctor Brockman, who was elected vice-speaker of the House in 1962, has served as a member of numerous KSMA committees, and as chairman of several. At present he is chairman of the Advisory Committee to the Editor of The Journal. He was appointed delegate to the AMA in April, 1961 and served until the end of that year. Doctor Brockman, as chairman of the KSMA Building Committee, helped to direct the planning and construction of the headquarters office. A 1935 graduate of the University of Louisville School of Medicine, he is secretary-treasurer of the Muhlenberg County Medical Society.

KSMA Delegates

ADAIR
Millard C. Loy, Columbia

ALLEN
F. J. Halcomb, Scottsville

ANDERSON
Boyd Caudill, Lawrenceburg

BALLARD
Glenn D. Baird, Bandana

BARREN
Eugene L. Marion, Glasgow

BATH

BELL
Charles Stacy, Pineville
M. J. Evans, Middlesboro

BOONE
LeRoy C. Hess, Florence

BOURBON
Richard J. Wever, Paris

BOYD
Walter Cawood, Ashland

BOYLE
Chris Jackson, Danville

BRACKEN
J. M. Stevenson, Brooksville

BREATHITT
Price Sewell, Jr., Jackson

BRECKINRIDGE
James G. Sills, Hardinsburg

BULLITT
R. S. Bowen, Mt. Washington

BUTLER
John C. Burris, Morgantown

CALDWELL
Ralph L. Cash, Princeton

CALLOWAY
Hugh L. Houston, Murray

CAMPBELL-KENTON
C. J. Brueggemann, Covington
Paul Klingenberg, Covington
Thomas Huth, Newport
R. Charles Smith, Newport
Richard A. Allnutt, Latonia
Robert T. Longshore, Covington

CARLISLE
John T. O'Neill, Arlington

CARROLL
Edgar S. Weaver, Carrollton

CARTER

CASEY

CHRISTIAN
Guinn S. Cost, Hopkinsville
Norma T. Shepherd, Hopkinsville

CLARK
Earl B. Rynerson, Winchester

CLAY
W. E. Becknell, Manchester

CLINTON
Ernest A. Barnes, Albany

CRITTENDEN
R. M. Brandon, Marion

CUMBERLAND
Joseph Schickel, Burkesville

DAVIESS
John S. Oldham, Owensboro
B. H. Warren, Owensboro
William W. Hall, Owensboro

EDMONSON
(Associated with Warren County)

ELLIOTT
John F. Greene, Sandy Hook

ESTILL
R. R. Snowden, Ravenna

FAYETTE
Andrew M. Moore, Lexington
W. L. Boswell, Lexington
Harvey Chenault, Lexington
Carl H. Fortune, Lexington
T. R. Bryant, Lexington
N. L. Bosworth, Lexington
Glenn U. Dorroh, Lexington
D. B. Stevens, Lexington
M. R. Gilliam, Lexington
J. H. Saunders, Lexington
R. D. Shepard, Lexington

FLEMING
L. W. Bowman, Flemingsburg

FLOYD
Russell L. Hall, Prestonsburg

FRANKLIN
John Stewart, Frankfort
B. B. Baughman, Frankfort

FULTON
G. F. Bushart, Fulton

GALLATIN
J. E. Esteves, Warsaw

GARRARD
Paul J. Sides, Lancaster

GRANT
C. C. Waldrop, Williamstown

GRAVES
Robert A. Orr, Mayfield

GRAYSON

GREEN
J. W. Miller, Greensburg

GREENUP

HANCOCK

HARDIN
Ruel T. Routt, Sonora

HARLAN
Philip J. Begley, Harlan
E. M. Howard, Harlan

HARRISON

HART

HENDERSON
Julian B. Cole, Henderson

HENRY
Sydney B. May, Eminence

HICKMAN
V. A. Jackson, Clinton

HOPKINS
Loman C. Trover, Madisonville
Frederick A. Scott, Madisonville

JACKSON

JEFFERSON
James W. Davis, Louisville
A. L. Goodman, Louisville
John A. Hemmer, Louisville
Richard E. Mardis, Louisville
Herman R. Moore, Jr., Louisville
James M. Riley, Jr., Louisville
John J. Robbins, Louisville
Paul J. Ross, Louisville
Bernard Schoo, Louisville
Sam Weakley, Louisville
Frank A. Bechtel, Louisville
Elbert G. Christian, Louisville
Morgan R. Colbert, Iouisville
William C. Durham, Louisville
Rudy J. Ellis, Louisville
Hollis Johnson, Louisville
George F. McAuliffe, Louisville
Samuel M. Smith, Louisville
Robert C. Tate, Louisville
Edward Warrick, Jr., Louisville
Samuel H. Black, Louisville
W. C. Gettelfinger, Louisville
David W. Kinnaird, Louisville
Homer B. Martin, Louisville
Robert L. McClendon, Louisville
Henry W. Post, Louisville
W. Fielding Rubel, Louisville
William T. Rumage, Jr., Louisville
William B. Stodghill, Louisville
John L. Wolford, Louisville

JESSAMINE
J. S. Williams, Nicholasville

JOHNSON
James W. Archer, Paintsville

KNOTT
Gene T. Watts, Hindman

KNOX
F. X. Sommer, Barbourville

LARUE
J. D. Handley, Hodgenville

LAUREL
E. C. Seeley, London

LAWRENCE
A. W. Wright, Louisa

LEE

LETCHER
Jim B. Tolliver, Whitesburg

LESLIE

LEWIS
Elwood Esham, Vanceburg

LINCOLN
H. L. Frisbie, Stanford

LIVINGSTON

LOGAN
J. P. Glenn, Russellville

LYON
James E. Hamilton, Eddyville

McCRACKEN
W. B. Haley, Paducah
R. M. Wooldridge, Paducah
G. H. Widener, Paducah

McCREARY
H. A. Perry, Stearns

McLEAN
W. Gerald Edds, Calhoun

MADISON
William G. Clouse, Richmond
William D. Epling, Berea

MAGOFFIN

MARION
David Drye, Bradfordsville

MARSHALL
Joseph R. Miller, Benton

MARTIN

MASON
Harry C. Denham, Maysville

MEADE
W. A. Cole, Jr., Brandenburg

MENIFEE
D. L. Graves, Frenchburg

MERCER
J. S. Baughman, Harrodsburg

METCALFE
P. D. Hitchcock, Edmonton

MONROE
John C. Marsh, Gamaliel

MONTGOMERY
R. J. Salisbury, Mt. Sterling

MORGAN
Morris L. Peyton, West Liberty

MUHLENBERG
Hylan H. Woodson, Greenville

NELSON
Tyre G. Forsee, Bardstown

NICHOLAS
W. R. Kingsolver, Carlisle

OHIO
R. E. Norsworthy, Hartford

OLDHAM
H. B. Mack, Pewee Valley

OWEN
O. A. Cull, Owenton

OWSLEY
Mildred B. Gabbard, Booneville

PENDLETON
W. M. Townsend, Falmouth

PERRY

PIKE
W. F. Clark, Pikeville
B. W. Cassady, Pikeville

POWELL

PULASKI
B. L. Ramsey, Somerset
M. A. Shepherd, Somerset

ROBERTSON

ROCKCASTLE

ROWAN

RUSSELL
Charles E. Peck, Russell Springs

SCOTT
J. C. Cantrill, Georgetown

SHELBY
A. D. Doak, Shelbyville

SIMPSON
L. F. Beasley, Franklin

SPENCER
M. H. Skaggs, Taylorsville

TAYLOR
Forest Shely, Campbellsville

TODD
R. D. Lynn, Elkton

TRIGG
John Futrell, Cadiz

TRIMBLE
John I. Cooper, Bedford

UNION

WARREN
Paul J. Parks, Bowling Green
L. Martin Wilson, Bowling Green

WASHINGTON
H. B. Simms, Springfield

WAYNE
John W. Simmons, Monticello

WEBSTER
John A. Logan, Sebree

WHITLEY
H. B. Barton, Corbin

WOLFE
Paul F. Maddox, Campton

WOODFORD
Norman S. Fisher, Midway

Open Meeting Planned Monday By Nominating Committee

Members wishing to confer with the KSMA Nominating Committee will have an opportunity to do so at an open meeting (location to be announced) scheduled following the close of the first session of the House of Delegates on Monday morning, September 28.

Final recommendations of the committee will be reported at the end of the first scientific session on Tuesday morning, September 29. Other nominations may be made from the floor at the House of Delegates meeting on Wednesday evening, September 30. At the close of the second session on Wednesday, the House will vote on the nominees.

Members of the nominating committee, headed by J. Sankey Williams, M.D., Nicholasville, are C. Melvin Bernhard, M.D., Louisville; N. L. Bosworth, M.D., Lexington; Richard E. Davis, M.D., Central City; and Paul F. Maddox, M.D., Campton.

Reference Committee Activity

At the first meeting of the KSMA House of Delegates at 9 a.m. on Monday, September 28, Speaker Garnett J. Sweeney, M.D., Liberty, will refer all officers' and committee reports and resolutions to one of seven reference committees. Reference committees will meet at **2 p.m. on Monday, September 28** on the 15th floor of the Kentucky Hotel. Members of the committees should meet for briefing sessions at 12:30 Monday in Parlor B at the Kentucky. **Any KSMA member wishing to testify on any resolution or report is urged to be present at 2 p.m.** In order to permit all who wish to speak to be heard, the open hearings will last about an hour. Following the open hearings, the committee will go into executive session to study the reports and review the testimony given.

The committees' recommendations will be made for presentation at the final session of the House in the Terrace Room of the Kentucky on Wednesday night, September 30. Reference committees appointed by Doctor Sweeney to serve during the 1964 session are listed below.

1963 Reference Committee Appointments

REFERENCE COMMITTEE NO. 1

Reports of Officers and Board of Trustees

Ballard W. Cassady, M.D., Pikeville, Chairman
Glenn W. Baird, M.D., Bandana
Walter L. Cawood, M.D., Ashland
Paul J. Ross, M.D., Louisville
George H. Widener, Jr., M.D., Paducah

REFERENCE COMMITTEE NO. 2

Scientific Assembly and Medical Education

Guinn S. Cost, M.D., Hopkinsville, Chairman
Richard A. Allnutt, M.D., Covington
Julian B. Cole, M.D., Henderson
Robert A. Orr, M.D., Mayfield
Samuel D. Weakley, Jr., M.D., Louisville

REFERENCE COMMITTEE NO. 3

Legislative Activities

Homer B. Martin, M.D., Louisville, Chairman
Harold B. Barton, M.D., Corbin
M. C. Loy, M.D., Columbia
James G. Sills, M.D., Hardinsburg
David B. Stevens, M.D., Lexington

REFERENCE COMMITTEE NO. 4

Public Service and Allied Professions

Paul H. Klingenberg, M.D., Covington, Chairman
William E. Becknell, M.D., Manchester
Andrew M. Moore, M.D., Lexington
Paul J. Sides, M.D., Lancaster
B. H. Warren, M.D., Owensboro

REFERENCE COMMITTEE NO. 5

Medical Service

David W. Kinnaird, M.D., Louisville, Chairman
Walter L. Boswell, M.D., Lexington
Carl J. Brueggemann, M.D., Covington
David Drye, M.D., Bradfordville
Claude C. Waldrop, M.D., Williamstown

REFERENCE COMMITTEE NO. 6

Constitution and Bylaws; Special Committees

N. Lewis Bosworth, M.D., Lexington, Chairman
J. S. Baughman, M.D., Harrodsburg
Donald Graves, M.D., Frenchburg
Ralph Lynn, M.D., Elkton
Henry Post, M.D., Louisville

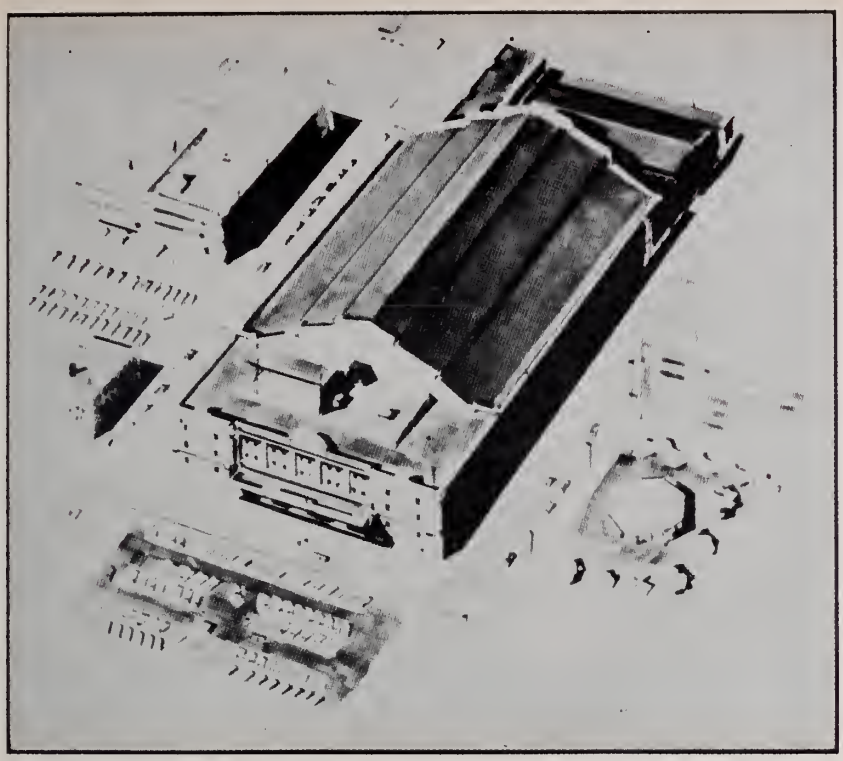
REFERENCE COMMITTEE NO. 7

Miscellaneous

L. F. Beasley, M.D., Franklin, Chairman
W. Gerald Edds, M.D., Calhoun
Joseph Saunders, M.D., Lexington
Charles E. Peck, M.D., Russell Springs
W. B. Haley, M.D., Paducah

CREDENTIALS COMMITTEE

Harvey Chenault, M.D., Lexington, Chairman
Frank A. Bechtel, M.D., Louisville
Norma T. E. Shepherd, M.D., Hopkinsville



Annual Meeting Special Features

• **SCIENTIFIC SESSIONS** featuring a Trans-Atlantic CPC, symposiums on diabetes and athletic injuries, scientific presentations, and panel discussions are scheduled daily on Tuesday, Wednesday, and Thursday, September 29, 30, and October 1.

• **SEVENTY-FIVE TECHNICAL EXHIBITS** featuring the best and newest in medical equipment, literature and pharmaceutical products will be presented at the Annual Meeting this year. Thirty-minute intermissions have been scheduled during each scientific and specialty group session for your convenience in visiting these interesting displays.

• **THE HOUSE OF DELEGATES,** KSMA's policy-making body, will meet twice during the 1964 Annual Meeting—on Monday morning, September 28 at 9 and on Wednesday evening, September 30. Officers for 1963-64 will be elected Wednesday night. The final session on Wednesday evening will be preceded by a subscription dinner at 6.

• **FOURTEEN SPECIALTY GROUPS** will hold sessions during the Annual Meeting. Four will meet Tuesday, eight on Wednesday, and two on Thursday. All members of KSMA are invited to attend these sessions. Outstanding guest speakers are scheduled to address the individual groups on their various fields of medicine.

• **THE PRESIDENT'S LUNCHEON** in the Terrace Room, Kentucky Hotel, at noon, Wednesday, September 28, will have Charles W. Jarvis, D.D.S., San Marcos, Tex., as speaker. This National known humorist will discuss "So—You Have a Problem?". Another highlight of the meeting will be the presentation of the three top KSMA awards and medical school faculty awards.

• **CLINICAL LABORATORY HEALTH EVALUATIONS,** a laboratory-testing program similar to that carried out at AMA meetings, will be provided by the Kentucky Society of Pathologists, assisted by several groups of medical technologists. The "laboratory" will be set up off the main scientific assembly hall.

• **ALUMNI REUNIONS** will be held by five year classes of the University of Louisville School of Medicine, beginning with the class of 1914 which will observe its 50th anniversary. A 4-hour cruise on the sternwheeler—the Belle of Louisville on Tuesday, September 29,—including a buffet supper, dancing, and door prizes will headline the alumni celebrations. Reservations for the cruise up the Ohio River will be limited to 600 persons.

Official Call

KSMA Annual Meeting

To the officers and members of the component county societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the KSMA will convene at the Convention Center, Louisville, on Tuesday, Wednesday, and Thursday, September 29 and 30 and October 1. The General session will be called to order at 9 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 9 a.m. Monday, September 28. The second regular business session will begin at 7 p.m. Wednesday, September 30. Both sessions will be held in the Terrace Room of the Kentucky Hotel.

Registration

The registration desk will open in the Convention Hall on the fourth floor of the Kentucky Hotel at 8 a.m. on Monday, September 28, and at 5:30 p.m., Wednesday, September 30. It will be open in the scientific assembly hall of the Convention Center from 8 a.m. to 5 p.m. on Tuesday, September 29, Wednesday, September 30, and Thursday, October 1.

Annual Meeting
Woman's Auxiliary to the KSMA

Tuesday, September 29

Pre-convention Board Breakfast (subscription): 8:00 a.m., Parlor B, Kentucky Hotel. All state officers, councilors, and committee chairmen, county auxiliary presidents, and the three immediate past state presidents are urged to attend.

Formal Opening of Convention: 10:00 a.m., Mirror Room, Kentucky Hotel

Luncheon (subscription) honoring past presidents, members-at-large, and distinguished guests: 12:30 p.m., Parlors B and C

Formal Convention Session: 2:00 p.m., Mirror Room

Wednesday, September 30

Formal Convention Session: 9:15 a.m., Mirror Room

Luncheon-Style Show (subscription) honoring Mrs. Richard A. Sutter, President-Elect, Woman's Auxiliary to AMA: 12:30 p.m., Flag Room

Gavel Club Dinner for Past State Presidents: 7:30 p.m.

Thursday, October 1

Post-convention Board Breakfast (subscription): 8:45 a.m., Parlor A

Dr. Jarvis is Featured Speaker At 1964 President's Luncheon

An entertaining analysis of the problems inherent in everyday life will be presented by Charles W. Jarvis, D.D.S., San Marcos, Texas, dentist-humorist, at the President's Luncheon during the KSMA Annual Meeting.



"So — You Have a Problem?" will be the topic of the amusing address given by Doctor Jarvis immediately following the luncheon in the Terrace Room of the Kentucky Hotel at noon Wednesday, September 30.

A member of the American Medical Association Speakers Bureau, Doctor Jarvis has gained national recognition as an entertaining and informative speaker. He held 141 speaking engagements last year.

A graduate of the University of Texas School of Dentistry, he is also a graduate engineer. Doctor Jarvis attended Texas A & M and the University of Houston before receiving his bachelor's degree from the United States Naval Academy.

Doctor Jarvis, a native Texan, is a veteran of World War II and was a carrier pilot in the U.S. Navy for three years. He is a member of the Texas and American Dental Association.

Your Annual Meeting Phone No. Is 584-2201 For Emergencies

A telephone call to 584-2201 (Area Code 502) will reach you at The KSMA Annual Meeting if you wish to be contacted by home, office, or hospital during your visit to Louisville.

Located in the middle of the Technical Exhibit Hall in Convention Center, the message center will provide convenient and efficient service for transferring your messages.

There will be no paging of individual physicians, due to the way facilities are arranged for the meeting.

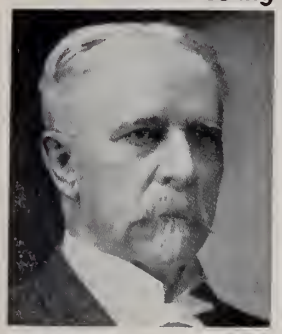
Only emergency calls will be posted on the blackboards to be placed in the entrance lobby of the Convention Center and in the Scientific Assembly Hall. *All* messages may be picked up at the message center. You are urged to check there for your calls.

The message center may be used as well to locate other physicians whom you may wish to contact after reaching town. Simply call 584-2201 and ask that your message be delivered.

George P. Archer, M.D., Prestonsburg, president of KSMA, has stressed the importance of making full use of the message center in order to obtain calls and messages quickly. The booth will be manned by trained employees of the Bell Telephone Company, sponsor of the message facilities.

A. D. Price Memorial Meeting To Honor 1883 KSMA President

The Kentucky State Medical Association's 1964 Annual Meeting will be officially titled The A. D. Price Memorial Meeting in honor of the 1883 president of KSMA.



The tradition of memorializing a former KSMA president or distinguished Kentucky physician each year at the Annual Meeting was instigated in 1935.

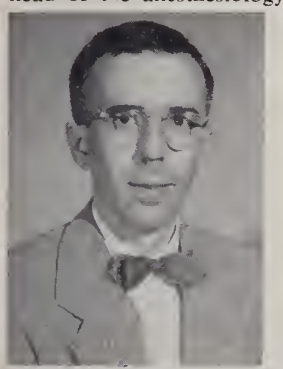
A biography of Doctor Price, written by KSMA Historian Eugene H. Conner, M.D., Louisville, will appear in the program booklet which will be distributed at the meeting September 28, 29 and October 1.

J. W. Holland, 1882 president, was honored at last year's meeting.

KSMA Official Historian

Eugene H. Connor, M.D., Louisville

Doctor Connor, professor of anesthesiology and head of the anesthesiology section at the University of Louisville School of Medicine, was named KSMA historian in April to succeed Emmet Field Horine, M.D., Brooks, who died in February after serving as historian for many years. A graduate of the University of Maryland School of Medicine in 1945, he was director of anesthesiology at Philadelphia General Hospital and assistant professor of anesthesiology at the University of Pennsylvania before coming to Louisville. From 1946-7 he served as a captain in the army assigned to the USAF at Wright Field, Ohio. Doctor Connor is Book Review Editor of the Journal of KSMA and chairman of the Library Committee of the University of Louisville School of Medicine. He was special editor of the 60th anniversary historical edition of the Journal published in Noember, 1963.



REGISTRATION

Please register at the Registration Booth in the north end of the Convention Hall (in the Technical Exhibit Hall) as soon as you are able. Hours are from 8 a.m. to 5 p.m., Tuesday, Wednesday and Thursday, September 29, 30, and October 1.

You are requested to wear your badges at all times while attending the meeting.



A MOONLIGHT CRUISE awaits U. of L. Medical Alumni on the evening of September 29, when the Belle of Louisville will leave the Fourth Street dock for a trip up the Ohio. All alumni of the medical school are invited to attend the reunion on board the Belle. Ten five-year classes beginning with the Class of 1914, are scheduled to hold reunions this year.

Cruise on Belle of Louisville Is Feature of Alumni Reunions

A four-hour moonlight cruise up the Ohio River on the Belle of Louisville will be the highlight of the U of L Medical School alumni reunions during the 1964 KSMA Annual Meeting, according to Walter C. Coe, M.D., Louisville, president of the Medical Alumni Association.

Ten five-year classes will hold reunions this year. The class of 1914 is celebrating its 50th and the Class of 1939, its 25th.

The ride on the Belle—one of the last American sternwheelers—is scheduled for Tuesday, September 29. The boat will leave the Fourth Street dock at 6 p.m. and return to 10 p.m. A delicious buffet supper and dancing to the orchestra of Jeanne Crume will be included in the cost of $4 a person.

Reservations will be limited to 600. You are urged to mail your reservation as soon as possible to Les Shively, director of alumni relations, University of Louisville.

For additional information on your class reunion contact your reunion chairman listed below.

1914 No Chairman

1919 No Chairman

1924 To be announced

1929 Margaret Limper, M.D., Louisville

1934 H. Davis Chipps, M.D., Lexington

1939 Herbert L. Clay, Jr., M.D., Louisville

1944 Charles O. Bruce, Jr., M.D., Louisville

1949 Charles Floyd, M.D., Gulfport, Miss.

1954 Milton F. Miller, M.D., Louisville

1959 Morton F. Wolfe, M.D., New Albany

House to Elect '64-'65 Officers At September 30 Session

KSMA Officers for the 1964-65 Associational year will be elected at the second session of the KSMA House of Delegates on Wednesday evening, September 30. Offices to be filled at that time are:

President-Elect	(Central)	One Year
Vice-Presidents	(Central)	One Year
	(Eastern)	One Year
	(Western)	One Year

Delegates to the AMA: two years (incumbent J. Thomas Giannini, M.D., Louisville)

Alternote Delegate to the AMA: two years (incumbent Charles G. Bryant, M.D., Louisville)

Trustees for five districts will be elected this year. Of the five incumbents, Howell J. Davis, M.D., Mitchel B. Denham, M.D.. Douglas E. Scott, M.D., and Clyde C. Sparks, M.D., have served only one full three-year term and are eligible for re-election. Donald Chatham, M.D., is currently serving an unexpired term ending in 1964 and is therefore also eligible to succeed himself. A list of incumbent trustees and their districts follows:

Second District (incumbent Howell J. Davis, M.D., Owensboro)

Seventh District (incumbent Donald Chotham, M.D., Shelbyville)

Ninth District (incumbent Mitchel B. Denham, M.D., Maysville)

Tenth District (incumbent Douglas E. Scott, M.D., Lexington)

Thirteenth District (incumbent Clyde C. Sparks, M.D., Ashland)

PLEASE TAKE THIS ISSUE HOME

Your wife may be interested in the special features presented in this issue of The Journal. In addition to the full program of her own meeting of The Woman's Auxiliary to KSMA, she will enjoy reading of the activities planned for the regular KSMA Annual Meeting. Changes in the Bylaws of the Auxiliary are also included. KSMA president George P. Archer urges that you carry this issue home to your wife for her information and enjoyment.

M.D.-Religious Groups to Meet

A number of Medical-Religious groups have made tentative plans for meetings on Wednesday Morning, September 30 during the KSMA Annual Meeting in Louisville, occording to William L. Woolfolk, M.D., Owensboro, chairman of the KSMA Committee on Medicine and Religion.

Breakfasts, communions, and other religious programs will be held from 7-8:45 a.m. Wednesday morning, the time period reserved for that purpose. Contact your own group for further information on time and place of these meetings.

Top KSMA Awards to be Given At President's Luncheon

KSMA's three traditional awards will be presented this year at the President's Luncheon in the Terrace Room of the Kentucky Hotel at noon, Wednesday, September 30, according to William H. Bizot, M.D., Louisville, chairman of the Awards Committee.

Physicians will be nominated by the awards commitee as recipients of the Distinguished Service Medal, given last year to Sam A. Overstreet, M.D., Louisville, and for the Outstanding General Practitioner Award, which was presented to Adam G. Osborne, M.D., Pikeville, in 1963. Also given again this year will be the R. Haynes Barr Award for a layman who is active in the public health field. Robert G. Matheson, Paducah, received the Barr Award last year.

The House of Delegates will make the selections of the two member awards recipients at its first meeting on Monday morning, September 28, on the basis of the nominations of the Awards Committee and any nominations from the floor.

Members of the Awards Committee with Doctor Bizot are: Neal Calhoun, M.D., Madisonville; Melvin L. Dean, M.D., Lexington; Ollie B. Emerine, M.D., Elizabethtown; and Richard H. Weddle, M.D., Somerset.

Health Evaluation Tests Offered For M.D.s at Annual Meeting

A Clinical Laboratory Health Evaluation test for discovering disease symptoms in Kentucky physicians will be carried out by the Kentucky Society of Pathologists at the 1964 Annual Meeting of the Kentucky State Medical Association in Louisville September 29, 30, and October 1.

The program is the first of its kind to be presented at a state medical association meeting, as far as it is known, though a similar testing operation has been carried out at the meetings of the American Medical Association in recent years. The Society of Pathologists will be assisted in the laboratory tests by the Kentucky, Louisville, and Central Societies of Medical Technologists.

The limited clinical examination program will be conveniently located off the main scientific Assembly Hall at the Convention Center. The tests will include six blood chemistry determinations, urinalysis, a hemocrit on blood and a white blood count.

Annual Meeting Section

Industrial M.D.s Name Officers

The new president of the Kentucky Industrial Medical Association is Arthur J. Shulthise, M.D., Louisville, who succeeds Frederick P. Shepherd, M.D., Louisville. New president-elect of the group is William P. Wharton, M.D., Lexington. John E. Eckerle, M.D., Louisville, remains as secretary-treasurer.

1964 Annual Meeting Program Summary

The Kentucky State Medical Association

September 29, 30 and October 1

Louisville

SUNDAY, SEPTEMBER 27

9:00 a.m.	Meeting of Board of Directors of Kentucky Physicians Mutual	Ship Room, Kentucky Hotel
12:30 p.m.	Luncheon Meeting, KSMA Board of Trustees	Parlor A, Kentucky Hotel

MONDAY, SEPTEMBER 28

9:00 a.m.	First Meeting of House of Delegates	Terrace Room, Kentucky Hotel
12:30 p.m.	Luncheon of Reference Committee Chairmen	Parlor A, Kentucky Hotel
2:00 p.m.	Reference Committee Meetings	15th Floor, Kentucky Hotel
4:00 p.m.	KEMPAC Political Seminar	Mirror Room, Kentucky Hotel
7:00 p.m.	KEMPAC Banquet	Mirror Room, Kentucky Hotel

TUESDAY, SEPTEMBER 29

8:00 a.m.	Registration ..... Technical Exhibit Hall, Convention Center
9:00 a.m.	Opening Ceremonies ..... Scientific Assembly Hall, Convention Center
9:20 a.m.	First Scientific Session ..... Scientific Assembly Hall, Convention Center
2:00 p.m.	Second Scientific Session ..... Scientific Assembly Hall, Convention Center
9:00 a.m.	Specialty Group Sessions (One Specialty Group will meet at this time. Any KSMA member may attend. See page 692 in program.)
2:00 p.m.	Specialty Group Sessions (Three Specialty Sessions will be held simultaneously at this time. Any KSMA member may attend any of these meetings. See pages 693 & 694 in program.)
5:30 p.m.	U. of L. Medical Alumni Cruise and Reunion ..... Belle of Louisville, Foot of Fourth Street

WEDNESDAY, SEPTEMBER 30

9:00 a.m.	Third Scientific Session ..... Scientific Assembly Hall, Convention Center
9:00 a.m.	Specialty Group Sessions (One Specialty Group will meet at this time. Any KSMA member may attend this meeting. See page 694 in program.)
11:50 a.m.	President's Luncheon ..... Terrace Room, Kentucky Hotel
2:00 p.m.	Specialty Group Sessions There will be no General Scientific Session on Wednesday Afternoon. (Seven Specialty Groups will meet simultaneously at this time. Any KSMA member may attend any of these meetings. See pages 695 & 696 in program.)
5:00 p.m.	Dinner Meeting, Board of Trustees ..... Parlor B, Kentucky Hotel
6:00 p.m.	Subscription Dinner and Meeting, House of Delegates ..... Terrace Room, Kentucky Hotel

THURSDAY, OCTOBER 1

9:00 a.m.	Fourth Scientific Session ..... Scientific Assembly Hall, Convention Center
9:00 a.m.	Specialty Group Sessions (One Specialty Group will meet at this time. Any KSMA member may attend this meeting. See page 697 in program.)
12:00 noon	Board of Trustees Meeting and Luncheon ..... Parlor A, Kentucky Hotel
2:00 p.m.-3:30 p.m.	Fifth Scientific Session ..... Scientific Assembly Hall, Convention Center
2:00 p.m.	Specialty Group Sessions (Two Specialty Groups will meet at this time. Any KSMA member may attend either of these meetings. See page 697 in program.)

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting the Scientific and Technical Exhibits.

(Full Scientific Program starts on page 692)

The Kentucky State Medical Association

SCIENTIFIC PROGRAM

A. D. Price Memorial Meeting

Convention Center, Louisville

TUESDAY, SEPTEMBER 29

MORNING SESSION

General Session

George P. Archer, M.D., Prestonsburg, KSMA President, Presiding

9:00 **Opening Ceremonies**
Welcome—George A. Sehlinger, M.D., Louisville
Invocation—E. Wade Weldon, D.D. District Superintendent, Louisville East District of The Methodist Church

9:20 **"The Clinical Aspects of Leptospirosis"**
R. S. Diaz-Rivera, M.D., Santurce, Puerto Rico

9:40 **"Cardiac Diagnosis from Examination of Arteries and Veins"**
Noble O. Fowler, M.D., Cincinnati, Ohio

10:00 **Visit Exhibits**

10:30 **President's Address**
George P. Archer, M.D., Prestonsburg, Kentucky

10:50 **"Renal Homotransplantation in Modified Recipients"**
George R. Prout, Jr., M.D., Richmond, Virginia

11:10 **"Hepatotoxicity in Anesthesia and Surgery"**
C. R. Stephen, M.D., Durham, North Carolina

11:30 **"Current Theories of Carcinogenesis"**
John R. McDonald, M.D., Detroit, Michigan

Lunch — 12:00 Noon

TUESDAY MORNING SESSION

Specialty Group Meeting

Kentucky Association of Public Health Physicians

Room 101—Convention Center

9:00 **"The Health Officer and His Public"**
Kenneth R. Byerly, Chapel Hill, North Carolina
Question and Answer Session

10:00 **Visit Exhibits**

10:30 **"The Objectives of the Department of Community Medicine in Physician Education."**
Jesse W. Tapp, M.D.

R. S. DIAZ RIVERA, M.D.

Santurce, Puerto Rico



Professor and chairman, department of medicine, University of Puerto Rico School of Medicine, San Juan. Received M.D. degree from the University of Louisville School of Medicine in 1939. Former lecturer in tropical medicine at the University of Pennsylvania, former assistant professor of pathology and medicine, University of Louisville. Also hos been chief of the medical service at San Juan City Hospital and chief of cardiavascular service, VA Hospital, San Juan. Fellow of the American College of Physicions and the American College of Cardiology and honorary member of the Southern Society for Clinical Research.

NOBLE O. FOWLER, M.D.

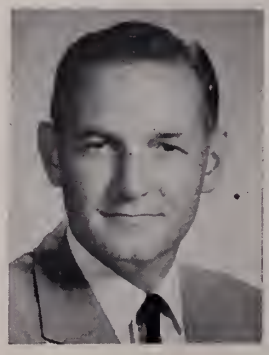
Cincinnati, O.



Prafessar of medicine at the University of Cincinnati School of Medicine and director of cardiac research at Cincinnati General Hospital. Also director of post-graduate training program in cardiology at the University of Cincinnati, and consultant in internal medicine at the Veterans Administration Hospital. Graduate of the University of Tennessee College of Medicine, 1941. Former research Fellow, American Heart Association. Farmerly on faculty of the State University of New York School of Medicine and Emory University School of Medicine. Diplomate of American Board of Internal Medicine and Fellow, American College of Physicians.

GEORGE R. PROUT, JR., M.D.

Richmond, Va.



Professor and chairman, division of uralagy, Medical College of Virginia, Richmond; M.D., Albany Medical College, Albany, N.Y., 1947; certified, American Board of Uralogy, 1959; American College of Surgeons; Society of Pelvic Surgeons, American Urological Association; James Ewing Society; American Society far the Study of Sterility; former associate professor and chairman, division of Urology, University of Miami School of Medicine; currently consultant in urology, McGuire Veterans Administration Hospital, Richmond, and consultant in urology, Richmond Crippled Children's Hospital.

TUESDAY AFTERNOON SESSION

General Session

Carlisle Morse, M.D., Louisville,
Vice-President (Central) Presiding

2:00 **"Toxemia in Pregnancy"**
Trans-Atlantic Telephone Medical Conference (Sponsored by Smith Kline and French Laboratories)
John W. Greene, Jr., M.D., Lexington, Kentucky, Moderator
Elsie R. Carrington, M.D., Philadelphia, Pennsylvania
Douglas M. Haynes, M.D., Louisville, Kentucky
Silas H. Starr, M.D., Louisville, Kentucky

3:00 **Visit Exhibits**

3:30 **"Cardiacs Can Work"**
Leon J. Warshaw, M.D., New York, New York

3:50 **"The Physician and the Press"**
Kenneth R. Byerly, Chapel Hill, North Carolina

4:50 **"The Physician's Contribution to Emotional Wellness"**
Trawick H. Stubbs, M.D., Atlanta, Georgia

TUESDAY AFTERNOON SESSION

Specialty Group Meetings
Kentucky Society of Anesthesiologists
Room 101—Convention Center

2:00 **"Digitalization in the Operating Room"**
Jan D. Hasbrouck, M.D., Lexington, Kentucky

2:30 **"Component Society Responsibility in the ASA Statement of Policy"**
Robert W. Lykins, M.D., Louisville, Kentucky

3:00 **Visit Exhibits**

3:30 **"The Use of Hyperbaric Oxygen"**
C. R. Stephen, M.D., Durham, North Carolina

4:30 **Business Meeting**

Kentucky Society of Pathologists
Room 204—Convention Center

2:00 **"Muscle Biopsy: Indications, Limitations and Interpretation"**
John R. McDonald, M.D., Detroit, Michigan

3:00 **Visit Exhibits**

3:30 **"Toxicology in a Small Hospital"**
Robert A. Stewart, M.D., Ashland, Kentucky

4:00 **"Fatty Acid Distribution in Three Types of Fatty Liver"**
Wellington B. Stewart, M.D., Lexington, Kentucky
James T. Packer, M.D., Lexington, Kentucky
Henry Tesluk, M.D., Lexington, Kentucky

4:30 **"Cancer of Sweat Glands"**
William Leslie Miller, M.D., Louisville, Kentucky

CHARLES R. STEPHEN, M.D.

Durham, N.C.



Professor of onesthesio, Duke University School of Medicine and chief, division of onesthesio ot Duke Hospitol. M.D.C.M., McGill University, Montreol, 1940. Diploma in Anesthetics, Royol College of Physicions ond Surgeons, Englond, 1946. Fellow af Americon College of Anesthesiology ond Diplomote, American Boord of Anesthesiology. Formerly on stoff of Neurological Institute ond of Children's Memoriol Hospitol ond post faculty member of McGill University. Doctor Stephen is o member af o number of medicol societies.

JOHN R. McDONALD, M.D.

Detroit, Mich.

Professor of surgical pothology, Woyne Stote University, Detroit; M.D., cum lounde, University of Monitoba, Winnipeg, Conoda, 1933; M.S. in pothology, University af Minnesoto (Moyo Foundotion), 1936; fellow, Americon Association for Tharacic Surgery; fellow, Americon College of Chest Physicions; member, Americon Medicol Association, Americon Society of Clinical Pothologists, Internotionol Academy of Pothology, ond Sigmo Xi; past president, Inter-Society Cytology Council; diplomote, Americon Board of Pothology; on Baord of Editors, Americon Journol of Clinical Pothology.



KENNETH R. BYERLY

Chapel Hill, N.C.



Associote professor, School of Journalism, University of North Carolina, ond lecturer, University of North Corolino School of Public Health; B.A., Business Administrotion, University of Minnesoto, 1930; M.A., Geogrophy, University of North Corolino, 1932; former owner ond publisher, Thermopolis, Wyo., **Independent Record**, Glendive, Mont., **Daily Ronger**; owner ond former publisher, Lewiston, Mont., **Daily News** ond **Argus Former**; owner, with sons, **The Tidewater News**, Fronklin, Vo.; former teocher, Clinton, N.C.; former member, Wyoming Legisloture; outhor of textbook, **Community Journalism.**

Kentucky Urological Society

Room 205—Convention Center

2:00 "LDH and Its Isozymes in Prostatic and Renal Neoplasms"
George R. Prout, Jr., M.D., Richmond, Virginia

3:00 Visit Exhibits

3:30 Pyelogram Hour

WEDNESDAY, SEPTEMBER 30

MORNING SESSION

General Session

Carl C. Cooper, M.D., Bedford, Vice-President (Eastern), Presiding

9:00 "Treatment of Metastatic Lesions to the Lung"
Alton Ochsner, M.D., New Orleans, Louisiana

9:20 "The Diagnosis and Clinical Management of Congenital Dysplasia and Congenital Dislocation of the Hip in Infancy"
H. Relton McCarroll, M.D., St. Louis, Missouri

9:40 "Baby Teeth are for Real"
Arthur M. Mickler, D.M.D., Louisville, Kentucky

10:00 Visit Exhibits

10:30 "Endotoxic Shock in the Obstetric Patient"
Elsie R. Carrington, M.D., Philadelphia, Pennsylvania

10:50 Presentation of Award

11:00 To Be Announced

PRESIDENT'S LUNCHEON

Terrace Room, Kentucky Hotel
11:50

George P. Archer, M.D., Prestonsburg, presiding

Invocation
Dr. Adrian Roberts, First Methodist Church, Prestonsburg

Recognition
George P. Archer, M.D.

Awards Presentation
William H. Bizot, M.D., Louisville, KSMA Awards Committee Chairman

"So—You Have A Problem?"
Charles W. Jarvis, D. D.S., San Marcos, Texas

WEDNESDAY MORNING SESSION

Specialty Group Meeting
Kentucky Industrial Medical Association

Room 101—Convention Center

10:00 "The Value of Periodic Medical Examinations"
Leon J. Warshaw, M.D., New York, New York
Group Discussion

ELSIE REID CARRINGTON, M.D.

Philadelphia, Pa.



Currently research professor of abstetrics and gynecology at the Womens Medical College of Pennsylvania ot Philadelphia. A 1941 graduate of Temple University Schaal af Medicine and farmer faculty member af that institutian. A member of the American Medical Assaciatian and the American College af Obstetrics and Gynecalogy. Farmer staff member af the Jane Lamb Memarial Haspital and Mercy Haspital, bath at Clintan, Iawa; farmer assistant chief af abstetrics and gynecalagy at Philadelphia General Haspital. Currently she is chief of ob-gyn service at Philadelphia General.

LEON J. WARSHAW, M.D.

New York, N. Y.



Visiting lecturer in accupatianal health, University af Califarnia, Las Angeles; former faculty member, Cornell Medical College, Columbia University College af Physicians and Surgeans, New Yark University Schaal af Medicine; M.D., Calumbia University College af Physicians and Surgeans, 1942; diplamate, Natianal Baard af Medical Examiners, American Board of Internal Medicine, American Baard af Preventive Medicine; fellow, American Callege af Cardialagy, American College af Physicians, Industrial Medical Assaciatian, American Public Health Assaciatian.

TRAWICK H. STUBBS, M.D.

Atlanta, Ga.



Directar, Cammunity Mental Health Service, Division of Mental Health, Geargia Deportment af Public Health; graduated from Emary University School of Medicine, 1940; M.P.H. degree from Harvard Schaal af Public Health, 1953; farmer assistant dean and assaciate prafessar af preventive medicine, Emory; former dean of Faculty of Medicine and prafessor af cammunity health, University of Missouri; farmer assistant director af the Department af Sacial Welfare, Divisian af Curative Services, State af Rhode Islond.

WEDNESDAY AFTERNOON SESSION

No General Session

All KSMA members are urged to attend any of these specialty group sessions.

Specialty Group Meetings

Kentucky Chapter, American College of Chest Physicians Meeting Jointly with the Kentucky Thoracic Society
Room 208—Convention Center

2:00 "Allergy in Chest Disease"
Armand E. Cohen, M.D., Louisville, Kentucky
2:20 "Mechanotherapy for Myocardia"
Richard B. McElvein, M.D., Lexington, Kentucky
3:00 Visit Exhibits
3:30 "Tuberculosis in Kentucky"
Michael L. Furcolow, M.D., Lexington, Kentucky
3:50 "Some Aspects of Pneumonia"
William H. Anderson, M.D., Louisville, Kentucky

Kentucky Academy of General Practice
Main Assembly Room—Convention Center

2:00 "Recent Advances in the Diagnosis and Treatment of Pericarditis"
Noble O. Fowler, M.D., Cincinnati, Ohio
Question and Answer Period
3:00 Visit Exhibits
3:30 "Orthopedics for General Practitioners"
Owen B. Murphy, M.D., Lexington, Kentucky
4:15 "Summary of Types of Obstetrical Anesthesia"
John W. Greene, Jr., M.D., Lexington, Kentucky

Kentucky Obstetrical and Gynecological Society
Room 204—Convention Center

2:00 "Fetal and Neonatal Jeopardy"
Elsie R. Carrington, M.D., Philadelphia, Pennsylviana
3:00 Visit Exhibits
3:30 Open Meeting of Maternal Mortality Committee of the Kentucky State Medical Association
Guest Panelist: Elsie R. Carrington, M.D.

Kentucky Orthopedic Society
Room 207—Convention Center

1:50 "Clinical Managemnt of Ununited Fractures of the Tibia"
H. Relton McCarroll, M.D., St. Louis, Missouri
2:20 "Guide-Wire Complications During Hip Nailings in Middle-Aged Adults"
Harold M. Childress, M.D., Jamestown, New York
2:40 "Blastomycosis Involving Bone"
O. James Hurt, M.D., Louisville, Kentucky
3:00 Visit Exhibits
3:30 "Innominate Osteotomy"
Audley Loughran, M.D., Lexington, Kentucky
Eugene Q. Parr, M.D., Lexington, Kentucky

ALTON OCHSNER, M.D.

New Orleans, La.



Director of surgery, Ochsner Clinic and Ochsner Foundation Hospital, New Orleans, emeritus professor of surgery, Tulane University School of Medicine; M.D., Washington University, St. Louis, 1920; consultant, Walter Reed Army Medical Hospital, Washington, D.C.; founder member of American Board of Surgery and American Board of Thoracic Surgery; past president, International Society of Surgery, Pan Pacific Surgical Association, American College of Surgeons, Southeastern Surgical Association, and Southern Surgical Association; AOA; Sigma Xi; ODK; Phi Beta Kappa; Kappa Delta Phi.

H. RELTON McCARROLL, M.D.

St. Louis, Mo.



Associate clinical professor of orthopaedic surgery, Washington University School of Medicine, St. Louis; graduated Washington University, 1931; post president, American Academy of Orthopaedic Surgeons; past president, Orthopaedic Section, American Medical Association; certified, American Boord of Orthopaedic Surgery; member of American Orthopaedic Association, Clinicol Orthopaedic Society, and American Acodemy of Orthopaedic Surgeons.

ARTHUR M. MICKLER, D.M.D.

Louisville, Ky.



Instructor of Pedodontics at the University of Louisville School of Denistry. He formerly held the same position at the University of Michigan. Now engaged in the privote practice of Pedodontics in Louisville. 1949 Graduate of the U. of L. School of Dentistry ond recipient of M.S. degree from the University of Michigan in 1951. Member of the Americon Society of Dentistry for Children and the Americon Acodemy of Pedodontics. Diplomate of the American Board of Pedodontics and former chief of dental stoff at Louisville Jewish Hospital.

3.50 **"Review of Spinal Fusions with and without Harrington Rod Immobilization at Shriners' Hospital, Lexington, Kentucky"**
Thomas D. Yocum, M.D., Lexington, Kentucky

4:10 **"Correction of Congenital Vertical Talus"**
Leonard A. Goddy, M.D., Louisville, Kentucky
Daniel G. Costigan, M.D., Louisville, Kentucky

Kentucky Chapter, American Academy of Pediatrics

Room 104—Convention Center

2:00 **"The Adolescent in Your Practice"**
Thomas E. Shaffer, M.D., Columbus, Ohio

3:00 **Visit Exhibits**

3:30 **"Electrolyte Disturbance in Children"**
William A. Brodsky, M.D., Louisville, Kentucky

Kentucky Chapter, American College of Physicians

Room 101—Convention Center

2:00 **"Iatrogenic Gout"**
C. Richard Gill, M.D., Lexington, Kentucky

2:20 **"Etiology and Managemnt of Complete Heart Block"**
Henry W. Post, M.D., Louisville, Kentucky

2:40 **"Left Heart Catheterization"**
Leonard Leight, M.D., Louisville, Kentucky

3:00 **Visit Exhibits**

3:30 **"Insulin Resistance and Insulin Antagonists"**
George J. Hamwi, M.D., Columbus, Ohio

4:00 **"Syphilis and Seroreactivity as Seen in Private Practice"**
Harold J. Schupbach, M.D., Owensboro, Kentucky

4:20 **"Percutaneous Splenoportography"**
John E. Myers, Jr., M.D., Lexington, Kentucky

Kentucky Psychiatric Association

Room 206—Convention Center

2:00 **"Private Practice of Psychiatry in Kentucky"—Survey**
Mrs. Anna Barker, Louisville, Kentucky

2:30 **"Post-Graduate Psychiatric Training for Non-Psychiatric Physicians"**
Warren M. Cox, M.D., Louisville, Kentucky

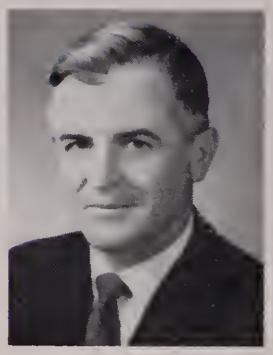
3:00 **Visit Exhibits**

3:30 **"Psychiatry's Double Binds"**
Trawick H. Stubbs, M.D., Atlanta, Georgia
(Panel of Discussants to be Announced)

4:30 **Annual Business Meeting**

MILES L. LEWIS, JR., M.D.

New Orleans, La.



Assistant professor of otolaryngology, Tulane University School of medicine; surgeon in chorge of otolaryngology at New Orleans Eye, Ear, Nose and Throat Hospital and current staff president of thot hospital; practice now limited to otology; graduated Tulane University School of Medicine, 1944; American Board of Otolaryngology; American Acodemy of Ophtholmology and Otolaryngology; American Laryngology, Rhinology, and Otology Society; American Otological Society.

D. EMERICK SZILAGYI, M.D.

Detroit, Mich.

Surgeon-in-chorge, division of general surgery, Henry Ford Hospital, Detroit. Notive of Hungary, received M.D. degree in 1935 at the University of Michigon. Former medical director of the Ford Rubber Plantation at Pora, Brazil, and former associate surgeon in the division of generol surgery ot Henry Ford Haspitol. Member of the American College of Surgeons, the American Thyroid Associotion, the Societe Internotionole de Chirurgie, the American Federotion for Clinical Research, the Society for Vascular Surgery, the Internotional Cardiovascular Society, and the Americon Surgical Association.



GEORGE J. HAMWI, M.D.

Columbus, O.



Director, department of clinical reseorch, Ohio State University College of Medicine; M.D., American University of Beirut, 1940; M.S., Ohio Stote University, 1947; past president, Ohio State Medical Associotion; fellow, American College of Physicians; member, Boord of Directors, American Diabetes Associotion; fellow, American Geriatrics Society; diplomate, American Boord of Internol Medicine; fellow, American College of Physicians; AOA; New York Academy of Sciences; Central Society for Clinical Research; American Federotion for Clinical Research.

THURSDAY OCTOBER 1

MORNING SESSION

General Session

John Dickinson, M.D., Glasgow, Vice-President (Western), Presiding

9:00 **"The Problem of the Dizzy Patient"**
Miles L. Lewis, Jr., M.D., New Orleans, Louisiana

9:20 **"Some Current Problems in the Surgery of Arteriosclerosis"**
D. Emerick Szilagyi, M.D., Detroit, Michigan

9:40 **"Nibbling and Gorging"**
George J. Hamwi, M.D., Columbus, Ohio

10:00 **Visit Exhibits**

10:30 **"Diabetes Symposium"**
(Supported by a grant from the Merck Sharp & Dohme Postgraduate Program)
Robert S. Tillett, M.D., Louisville, Kentucky, Moderator
Elsie R. Carrington, M.D., Philadelphia, Pennsylvania
George J. Hamwi, M.D., Columbus, Ohio
Thomas E. Shaffer, M.D., Columbus, Ohio
D. Emerick Szilagyi, M.D., Detroit, Michigan

Lunch — 12:00 Noon

THURSDAY MORNING SESSION

Specialty Group Meeting

Kentucky Eye, Ear, Nose & Throat Society— Room 101—Convention Center

9:00 **"Cataract Removal in the Young Patient" (Aspiration Technique),**
Thomas E. Campbell, M.D., Louisville, Kentucky

9:45 **"Uncommon Middle Ear Problems and Their Surgical Correction**
Miles L. Lewis, Jr., M.D., New Orleans, Louisiana

10:30 **Visit Exhibits**

11:00 **"Herpes Simplex of the Eye"**
James H. Allen, M.D., New Orleans, Louisiana

THURSDAY AFTERNOON SESSION

General Session

Delmas M. Clardy, M.D., Hopkinsville, KSMA President, Presiding

2:00 **"Athletic Injury Prevntion Panel"**
"Some Mdical Problems in High School Athletics"
Thomas E. Shaffer, M.D., Columbus, Ohio
"Conditioning for Sports"
O. B. Murphy, M.D., Lexington, Kentucky

Question and Answer Session

3:00 **Adjournment of General Scientific Session**

THOMAS E. SHAFFER, M.D.

Columbus, O.

Professor, deportment of pediotrics Ohio Stote University College of Medicine, ond director of Medical Services ot Juvenile Diognostic Center of Ohio Youth Commission, M.D. from Cornell University Medical College, 1931; former instructor, deportment of pediotrics, Yale University School of Medicine; former professor of preventive pediotrics ot Temple University; fellow, Americon Academy of Pediotrics, American College of Sports Medicine, ond Americon Public Heolth Associotion; diplomote, Americon Boord of Pediotrics. Member, A.M.A. Committee on Medicol Aspects of Sports.



THURSDAY AFTERNOON SESSION

Specialty Group Meeting

Kentucky Eye, Ear, Nose & Throat Society— Room 101—Convention Center

1:00 **"Diagnosis of Brain Tumors"**
Thomas M. Marshall, M.D., Louisville, Kentucky

1:45 **"Problems of Hematologoy in Otolaryngology"**
Ellis A. Fuller, M.D., Louisviille, Kentucky

2:30 **Visit Exhibits**

3:00 **"Simplified Glaucoma Procedures"**
James H. Allen, M.D., New Orleans, Louisiana

3:45 **"Practical Pathological Eye Lessons"**
Roderick MacDonald, Jr., M.D., Louisville, Kentucky

Kentucky Chapter, American College of Surgeons—Room 104—Convention Center

2:00 **"Behavior and Managemnt of Major Acute Bleeding from Peptic Ulcers"**
Joseph Hamilton, M.D., Louisville, Kentucky
Phillip Harbrecht, M.D., Louisville, Kentucky
Robert Robbins, M.D., Louisville, Kentucky
Gerre Nolan, Ph.D., Louisville, Kentucky

2:30 **"Thrombo-Angiitis of Abliterans Clinical and Angeographic Collelation"**
D. Emerick Szilagyi, M.D., Detroit, Michigan

3:00 **Visit Exhibits**

3:30 **"Spin Off" in Cardiac Surgery"**
W. Fielding Rubel, M.D., Louisville, Kentucky

4:00 **"The Protective Effect of ATP in Experimental Hemorrhagic Shock"**
G. P. Sharma, M.D., Lexington, Kentucky
Ben Eiseman, M.D., Lexington, Kentucky

1964 Scientific Exhibits to Emphasize Latest in Progress and Research

Eighteen scientific exhibits featuring the latest findings of medical research and progress in the field of medicine will be an attraction of the 1964 KSMA Annual Meeting, according to Benjamin B. Jackson, M.D., Louisville, chairman of the KSMA Committee on Scientific Exhibits.

Located in the Convention Center between the Technical Exhibit Hall and the main Scientific Assembly Hall, the exhibits are conveniently arranged for easy access.

A plaque will be awarded again this year for the third time to the exhibit judged best. Each exhibitor taking part in the 1964 Annual Meeting will receive a certificate.

Scientific Exhibitors

Arterial Reconstruction in Gangrenous Extremities
David A. Hull, M.D., Gordon L. Hyde, M.D.
Lexington Medical Center

Organ Scanning with Radioisotopes
H. L. Townsend, M.D., Houston Hedges, M.D., John D. Hummel, M.D.
Kentucky Baptist Hospital

Know Your Eyes
Ira A. Abrahamson, Sr., M.D., Ira A. Abrahamson, Jr., M.D.
Cincinnati, Ohio

Doctor, Are You sure You Can Rely on Your Laboratory?
Kentucky Society of Pathologists

Mammography, Its Application in Breast Pathology
William Rumage, Jr., M.D., Joan Hale, M.D., Emileano Quilala, M.D.
Norton Memorial Infirmary, Louisville

Hiatal Hernia Repair: Abdominal Approach
Charles H. Moore, M.D., Khamis I. Saba, M.D.
Good Samaritan Hospital, Cincinnati, Ohio

Ischemia
Benjamin B. Jackson, M.D.
Louisville, Kentucky

P. K. U., (Phenylketonurial
Helen B. Fraser, M.D., M.P.H.
State Department of Health

Automotive Crash Injury Research
Cornell Aeronautical Laboratory, Inc.
Cornell University

Simultaneous Right Inguinal Hernioplasty and Appendectomy—Increasing the Yield
George B. Sanders, M.D.
University of Louisville School of Medicine

Surgery of the Rheumatoid Hand
Paul M. Weeks, M.D.
University of Kentucky Medical Center

Gastric Tumors
Coleman C. Johnston, M.D., Bahram Moshiry, M.D. Gultekin Ertugrul, M.D.
St. Joseph Hospital, Lexington

Ecthyma Contagiosum
U. W. Leavell, M.D., M. J. McNamara, M.D., R. J. Muelling, M.D.
University of Kentucky Medical Center

Coarctation of Aorta
W. Porter Mayo, M.D., Graydon A. Long, M.D.
Richard B. McElvein, M.D.
Lexington, Kentucky

Vector Cardiography by Scalar Analysis
George F. Brockman, M.D.
Muhlenberg Community Hospital

The Kentuckiana Ileostomy and Colostomy Club—A Mutual Self-Help Organization for your "Ostomy" Patients
The Kentuckiana Ileostomy & Colostomy Club

Ligation of Perforator Veins in the Treatment of Venous Stasis Ulcers
Giles Stephens, M. D.
Louisville Veterans Administration Hospital

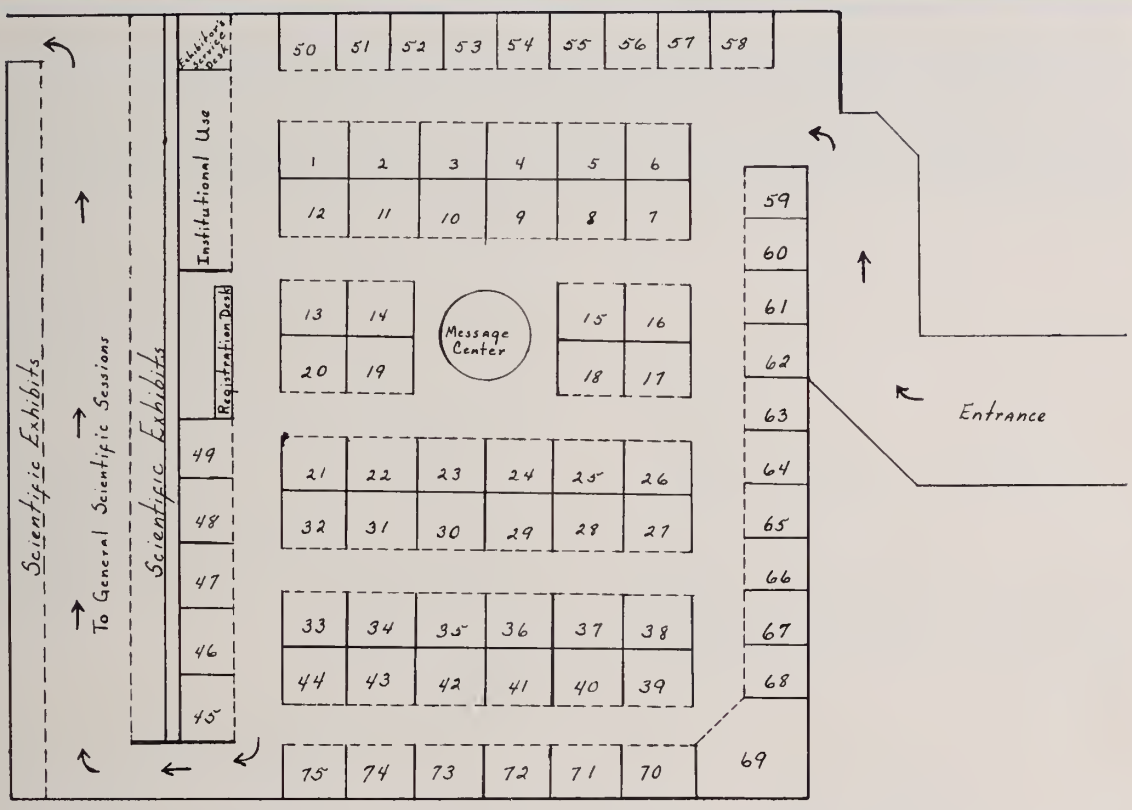
Differential Diagnosis of Syphilis
State Department of Health

Technical Exhibits Will Feature Newest and Best Medical Products

A wide range of important products, literature and ideas will be made available to Kentucky physicians by the 75 technical exhibits scheduled for the 1964 KSMA Annual Meeting.

A 30-minute intermission has been arranged for each morning and afternoon General Scientific Session and during the meetings of the Specialty Groups so that every physician will have time to visit both Scientific and Technical Exhibits. Each member is urged to take this opportunity to visit all the exhibits.

TECHNICAL EXHIBITORS



Abbott Laboratories (46)
Ames Company, Inc. (63)
Armour Pharmaceutical Co. (4)
Arnar-Stone Laboratories, Inc. (38)
Audio-Digest Company (70)
Ayerst Laboratories (59)
Baker Laboratories, Inc. (66)
Blue Cross - Blue Shield (25)
Borchert Co. (41)
Bristol Laboratories (68)
Brown Shoe Co. (53)
Burroughs Wellcome & Co., Inc. (60)
Burton, Parsons & Co., Inc. (33)
Ciba Pharmaceutical Co. (9)
The Coca-Cola Co. (69)
F. E. Compton Co. (62)
Coreco Research Corp. (67)
Dictaphone Corp. (29)
Dome Chemicals, Inc. (54)
Eaton Laboratories (1)
The Emko Co. (40)
Encyclopaedia Britannica (56)
Geigy Pharmaceuticals (12)
Gerber Products Co. (39)
Grogan's, Inc. (55)
Guild of Prescription Opticians of Ky. (10)
Max Wocher & Son Co. (23)
John Hancock Insurance Co. (75)
Johnson & Johnson (45)
Kay Surgical, Inc. (13)
Lederle Laboratories (19)
Eli Lilly & Co. (47)
J. B. Lippincott Co. (5)
Lloyd Brothers, Inc. (74)
Lloyd, Dabney & Westerfield, Inc. (34)
J. A. Majors Co. (7)
Malkin Instrument Co. (32)
McNeil Laboratories, Inc. (57)
Mead Johnson Laboratories (18)
Medco (64)
Medical Protective Co. (72)
Merck Sharp & Dohme (26)
C. V. Mosby Co. (52)
National Cash Register Co. (50)
Ortho Pharmaceutical Corp. (20)
Parke, Davis & Co. (14)
Pfizer Laboratories (48)
William P. Poythress & Co., Inc. (61)
R. J. Reynolds Tobacco Co. (36)
A. H. Robins Co., Inc. (8)
Roche Laboratories (58)
William H. Rorer, Inc. (30)
Ross Laboratories (11)
Sandoz Pharmaceuticals (24)
Schering Corp. (48)
Julius Schmid, Inc. (22)
G. D. Searle & Co. (16)
Sherman Laboratories (51)
Siemens (65)
Smith Kline & French Laboratories (21)
Smith, Miller & Patch, Inc. (44)
E. R. Squibb & Sons (31)
Stuart Co., Div. Atlas Chemical (17)
Syntex Laboratories, Inc. (2 & 35)
Tafel Surgical Supply Co., Inc. (28)
Thermo-Fax Sales, Inc.
United States Tobacco Co. (3)
U.S. Vitamin & Pharmaceutical Corp. (42)
Upjohn Company (6)
W-T-S Pharmaceuticals (73)
Wallace Laboratories (15)
Warner-Chilcott Laboratories (43)
Warren-Teed Pharmaceuticals, Inc. (71)
Westwood Pharmaceuticals (27)

PROGRAM

FORTY-SECOND ANNUAL CONVENTION

OF THE

WOMAN'S AUXILIARY

TO THE

KENTUCKY STATE MEDICAL ASSOCIATION

SEPTEMBER 29 — OCTOBER 1

1964

KENTUCKY HOTEL **LOUISVILLE, KENTUCKY**

General Information

REGISTRATION

Lobby, Kentucky Hotel

Monday	12 noon - 5:00 p.m.
Tuesday	8:00 a.m. - 5:00 p.m.
Wednesday	9:00 a.m. - 11:00 a.m.

TUESDAY, SEPTEMBER 29

8:00 A.M.

Pre-convention Board Breakfast (subscription): Parlor B, Kentucky Hotel. All state officers, councilors, and committee chairmen, county auxiliary presidents, and the three immediate past state presidents are urged to attend.

10:00 A.M.

MIRROR ROOM

Formal opening of the 42nd Annual Convention of the Woman's Auxiliary to the Kentucky State Medical Association

Mrs. J. Murray Kinsman, President, presiding

Invocation .....Mrs. Thomas G. Parker, Murray
Pledge of Allegiance to the Flag
Mrs. Carlos E. Hernandez, Elizabethtown
Pledge of Loyalty .....Mrs. Earl W. Roles, Louisville
National Vice-President
Address of Welcome..Mrs. Bernard J. Schoo, Louisville
President, Jefferson County Auxiliary
Presentation of Distinguished Guests
Mrs. J. Murray Kinsman, Louisville
Adoption of Convention Rules..Mrs. C. Melvin Bernhard
Louisville, Parliamentarian
Announcements ..Mrs. William C. Durham, Louisville
Convention Chairman
Roll Call of Delegates.....Mrs. Robert J. Salisbury
Mt. Sterling, Recording Secretary
Minutes of the 41st Annual Convention
Mrs. Robert J. Salisbury
Report of the 1964 National Convention
Mrs. James Sears Rich, Lexington
Immediate Past President
Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association
Mrs. William W. Wainer, Providence
Greetings .....Mrs. Paul Gray, Batesville, Arkansas
President, Woman's Auxiliary to the
Southern Medical Association
President's Address .....Mrs. J. Murray Kinsman
Reports of Officers
President-Elect and Membership Chairman
Mrs. J. Jack Martin, Tompkinsville
Vice-Presidents .....Mrs. Paul F. Rizk, Grayson
Mrs. O. L. May, Danville
Mrs. Ballard Cassady, Pikeville
Mrs. Charles Kissinger, Henderson
Treasurer .....Mrs. Graydon A. Long, Lexington
Corresponding Secretary ....Mrs. Meyer M. Harrison
Louisville
Reports of Councilors
Reports of Chairmen
Old Business
New Business
Report of Nominating Committee
Mrs. James Sears Rich, Chairman
Presentation of the 1964-1965 Budget
Mrs. David M. Cox, Louisville
Finance Chairman
Election of 1964-65 Nominating Committee

Report of Registration .....Mrs. Morgan R. Colbert
Louisville
In Memoriam ....Mrs. Frank T. Smith, Middlesboro
Participants:
Mrs. Philip E. Blackerby, Louisville
Mrs. John B. Floyd, Richmond
Mrs. Jesse T. Funk, Bowling Green

LUNCHEON

12:30 P.M.

PARLORS B AND C

Honoring

Past Presidents, Members-at-Large, and Distinguished Guests
Invocation .....Mrs. Paul E. Lett, Lancaster
Chairman, International Health Activities
Presentation of Membership Awards
Mrs. J. Jack Martin
"S. S. HOPE" ..Ludwig H. Segerberg, M.D., Louisville
John C. Weeter, M.D., Louisville
William M. Wyatt, M.D., Somerset

2:00 P.M.

MIRROR ROOM

Address ..... Delmas M. Clardy, M.D., Hopkinsville
President-elect, KSMA

Reports of County Auxiliary Presidents
Vice-Presidents presiding: Mrs. Paul F. Rizk
Mrs. O. L. May
Mrs. Ballard Cassady
Mrs. Charles Kissinger

Bell, Boyd - Carter - Greenup, Boyle, Calloway, Daviess, Fayette, Franklin, Fulton, Hardin-Larue, Harlan, Henderson, Hopkins, Jefferson, Johnson-Floyd-Magoffin, Laurel, Madison, Marion-Washington, Mason, McCracken, Montgomery-Bath, Muhlenberg, Perry-Knott, Pike, Pulaski, Warren, Whitley

WEDNESDAY, SEPTEMBER 30

9:15 A.M.

MIRROR ROOM

Invocation ..... Mrs. Robert Long, Somerset
Roll Call ..... Mrs. Robert J. Salisbury
Reading of Minutes ..... Mrs. Robert J. Salisbury
Presentation of Distinguished Guests
Announcements ..... Mrs. William C. Durham
Address ..... George P. Archer, M.D., Prestonsburg
President, KSMA
Presentation of Community Service Award
George P. Archer, M.D.
Address .. Mrs. Richard A. Sutter, St. Louis, Missouri
President-Elect, Woman's Auxiliary to AMA
Election of Officers
Installation of Officers ..... Mrs. Richard A. Sutter
Presentation of Gavel and Pin .. Mrs. J. Murray Kinsman
Inaugural Address ..... Mrs. J. Jack Martin
Announcement of Committee Chairmen
Mrs. J. Jack Martin
Final Report of Registration ... Mrs. Morgan R. Colbert
Courtesy Resolutions .. Mrs. Clyde Cecil Sparks, Ashland

LUNCHEON AND STYLE SHOW

12:30 P.M.

FLAG ROOM

Honoring

Mrs. Richard A. Sutter, President-Elect
Woman's Auxiliary to the American Medical Association
Invocation ..... Mrs. Harold B. Graves, Louisville
President-Elect, Jefferson County Auxiliary
Presentation of Distinguished Guests
Presentation of Past Presidents
Presentation of Officers
Style Show
Adjournment

THURSDAY, OCTOBER 1

8:45 A.M.

PARLOR A

Post-convention Board Breakfast
Presiding ..... Mrs. J. Jack Martin, President
Invocation ..... Mrs. Carson E. Crabtree, Buffalo

Meeting of Membership Committee

RULES OF THE CONVENTION

1. Badges must be worn by the voting body during all general sessions.
2. Delegates' privileges are transferable only with the knowledge and approval of the Credentials Committee.
3. Officers and delegates are requested to sit in the sections assigned to them. All persons appearing on the program are requested to sit near the front.
4. When addressing the Chair, a speaker shall announce her name and the name of her county auxiliary.
5. Each speaker from the floor shall be limited to *two* minutes. No one shall speak more than twice on the same question.
6. Officers giving reports shall be limited to *five* minutes.
7. County presidents giving reports shall be limited to *two* minutes unless more time is specified by the president.
8. A time keeper shall notify each speaker when the allotted time has expired.
9. Only a voting member shall offer motions and vote. Motions must be in writing, signed by the mover, and presented to the recording secretary, when so requested by the Chair.
10. No announcements shall be made from the floor. All announcements of a vital nature shall be made from the platform with the consent of the president after they have been submitted in writing to her.
11. The right to the floor may be granted to non-delegate members by consent of the Chair or by majority vote of the delegates.
12. Visitors are welcome at all the general sessions. All visitors and auxiliary members are requested to register.

Pledge of Loyalty

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

STATE OFFICERS

President ..... Mrs. J. Murray Kinsman, Louisville
President-Elect .... Mrs. J. Jack Martin, Tompkinsville
First Vice-President ..... Mrs. Paul F. Rizk, Grayson
Second Vice-President ..... Mrs. O. L. May, Danville
Third Vice-President .... Mrs. Ballard Cassady, Pikeville
Fourth Vice-President ..... Mrs. Charles Kissinger
Henderson
Recording Secretary ..... Mrs. Robert J. Salisbury
Mt. Sterling
Treasurer ..... Mrs. Graydon A. Long, Lexington
Corresponding Secretary ..... Mrs. Meyer M. Harrison
Louisville
Parliamentarian .. Mrs. C. Melvin Bernhard, Louisville

PROPOSED AMENDMENTS TO THE CONSTITUTION AND BYLAWS TO BE PRESENTED TO THE FORTY-SECOND ANNUAL CONVENTION

The Constitution and Bylaws have been edited by the bylaws committee. Changes in wording have been made for purposes of clarification. "The co-ordinator for members-at-large" has been added in all instances where appropriate. The standing committees enumerated in Article IV of the Bylaws have been named to correspond to those of the Woman's Auxiliary to the American Medical Association. The duties of the committee chairmen have been rewritten to denote the services they perform.

The Forty-First Annual Convention of the Woman's Auxiliary to the American Medical Association voted to amend the bylaws by raising dues from one dollar to two dollars per member which includes a subscription to the official National publication. This amendment becomes effective July 1, 1965. By this action Bulletin Circulation Committee was eliminated.

Amendment #1 Article II—Objectives—a (page 1 of Constitution). Amend by substituting for the present section the following:

"To assist the Kentucky State Medical Association in its program for the advancement of medicine and health education."

Amendment #2 Article VI—Membership—Section 1. (page 2 of Constitution). Amend by striking out the word "demise" on last line and substituting "death". Add "or retirement". If amended would read:

"The members may be the wives, mothers, daughters, sisters, or widows of doctors. The doctors must be in good standing in the Kentucky State Medical Association and/or the American Medical Association, or have been in good standing at the time of their death or retirement."

Amendment #3 Article VI—Membership—Section 2. (page 3 of Constitution). Amend by substituting for the present section the following:

Membership in the Auxiliary shall be composed of:

A. Active members

Only wives and widows are eligible to serve as elected officers or as delegates to the National Convention.

1. Members of organized auxiliaries
2. Members-at-large
3. Honorary members

B. Associate members

Amendment #4 Article VI—Membership—Section 3. (page 3 of Constitution). Amend by deleting in entirety. If amended Section 4 becomes Section 3. Amend by substituting for the present section the following:

"Members-at-large shall be those who reside in counties in which there are no component auxiliaries."

Amendment #5 Article VI—Membership—Sections 5 and 6 become 4 and 5. Amend by changing old Section 6 to Section 4. Amend old Section 5. If amended would read:

"Associate members shall be the wives of associate members of the Kentucky State Medical Association. Members of the Kentucky State Medical Association who are the wives of physicians shall be eligible to associate membership in the Auxiliary. Associate members shall be entitled to all the rights and privileges of active members except the right to vote and to hold elective office.

Amendment #6 Article VII—The Convention—Section 3. (page 5 of Constitution). Amend by adding (d). If amended would read:

"Members-at-large named as delegates by the president with the approval of the Board of Directors. The number of such delegates or alternates shall not exceed one for each 25 members-at-large or major fraction thereof, except as they serve in other classifications. Only one such delegate or alternate shall be named from a county.

Amendment #7 Article X—(page 8 of Constitution) Amend by inserting new Article X—The Executive Committee.

Section 1. The Executive Committee shall consist of the president, the president-elect, the treasurer, and the recording secretary.

Section 2. The Executive Committee shall read and correct the minutes of the final session of the Convention.

Section 3. The Executive Committee shall transact such emergency business as may arise between regular meetings of the Board of Directors.

Amendment #8 Former Article X, if amended, becomes Article XI (page 8 of Constitution). On line seven insert "shall have been printed in the Blue Grass News". If amended would read:

This Constitution and Bylaws may be amended at any Convention by a two-thirds vote provided that (a) the proposed amendment shall have been submitted in writing to the chairman of the bylaws committee at least six months prior to the Convention at which it is to be acted upon, (b) the proposed amendment shall have been printed in the Blue Grass News with the call for the annual convention at which it is to be acted upon.

Amendment #9 Article I—The Convention (page 9 of Bylaws). Amend by inserting (1.), (2.), and (3.) under "c" of Section 1. If amended would read:

c. Reading and adoption of minutes

1. Minutes of all business sessions except those of the final day of Convention may be corrected and approved by a special committee appointed by the presiding officer.
2. The new Executive Committee shall read and correct the minutes of the final session of the Convention.
3. An abstract of the Convention minutes shall be published in the written annual report of the Board of Directors. (Any action taken shall be published in full.)

Amendment #10 Article II—Election of General Officers (page 11 of Bylaws). Section 6. Amend by substituting for the present section the following:

"The four vice-presidents, the recording secretary, and the treasurer may serve more than one term, but not more than three consecutive terms. If a vacancy occurs in these offices, the president shall appoint an active member to serve the unexpired portion of the term. The appointment is subject to approval by the Board of Directors.

Amendment #11 Article II—Election of General Officers (page 11 of Bylaws) Section 8. Amend by striking out "August" on third line and inserting "February". If amended would read:

"It shall be the duty of the nominating committee to have the slate prepared by February 1.

Amendment #12 Article III—Duties of the Officers, Councilors and Co-ordinator For Members-At-Large Section 2. (page 13 of Bylaws). Amend by substituting for the third paragraph the following:

"She shall appoint the councilors, the co-ordinator for members-at-large, and the chairmen of the standing committees subject to the approval of the Executive Committee.

Amendment #13 Article III—Duties of the Officers, Councilors, and Co-ordinator for Members-At-Large —Section 2. (page 13 of Bylaws). Amend by substituting for the eighth paragraph the following: "Subject to the approval of the Executive Committee, the president shall appoint a general chairman to be responsible for the arrangements for the Annual Convention. The members of the convention committee shall be appointed by the chairman with the approval of the president."

Amendment #14 Article III—Duties of the Officers, Councilors, and Co-ordinator for Members-At-Large —Section 5. (page 14 of Bylaws). Amend by substituting the following:

"The recording secretary shall keep the minutes of the Convention, of the Fall Conference, and of the meetings of the Executive Committee and of the Board of Directors."

Amendment #15 Article III—Duties of the Officers, Councilors, and Co-ordinator for Members-At-Large —Section 7. (page 15 of Bylaws). Amend by inserting paragraph 6 as follows:

"She shall serve on the membership committee".

Amendment #16 Article III—Duties of the Officers, Councilors, and Co-ordinator for Members-At-Large —(page 16 of Bylaws). Amend by adding Section 9.

"The Co-ordinator for Members-At-Large shall serve on the membership committee. She shall assist with recruitment of members-at-large and shall encourage organization of county auxiliaries."

Amendment #17 Article IV—Standing Committees and Their Duties—Section 23. (new) Amend by inserting the following:

"The nominating committee shall meet in the fall and select candidates for the offices of president-elect, four vice-presidents, recording secretary, and treasurer. The slate shall be presented to the president no later than February 1.

Amendment #18 Article VI—Dues— Sections 1 through 6. Amend Sections 1, 2, 3, 5, and 6 by striking out "three" and insert—"four". Amend Section 4, by striking out "one" and inserting "two".

Amendment #19 Article VII—Official Publication. Amend by striking out "Kentucky State Medical Journal" and inserting "Blue Grass News". If amended would read:

"The official publication of the Auxiliary shall be the Blue Grass News in which shall be published all official Auxiliary notices and the program for the Convention."

Amendment #20 Article IX—Component Auxiliaries —Section 3. Amend by striking out "three" and inserting "four".

Amendment #21 Article IX—Component Auxiliaries —Section 4. Amend by substituting for the present section the following:

"County auxiliary officers shall be elected in the spring and they shall be installed before June 10."

Mrs. J. Andrew Bowen
Mrs. John S. Harter
Mrs. J. Murray Kinsman
Mrs. Marvin Lucas
Mrs. Carlisle Morse
Mrs. Earl W. Roles
Mrs. C. Melvin Bernhard, Chairman
By-Laws Committee

1964 State Convention Committees

General Chairman.....Mrs. William C. Durham Louisville
Registration.....Mrs. Morgan R. Colbert, Louisville
Decorations.....Mrs. Walter Fox, Louisville
Mrs. William J. Hockaday, Louisville
Finance.....Mrs. David W. Griffin, Louisville
Publicity.....Mrs. Walter S. Coe, Louisville
Exhibits.....Mrs. Charles K. Sergeant, Louisville
Luncheon-Style Show..Mrs. Charles P. Davis, Louisville
Style Show Tickets..Mrs. William F. Hawn, Louisville
Tickets.....Mrs. W. Procter Eubank, Louisville
Official Hostesses..Mrs. Raymond E. Jones, Louisville
Mrs. Charles F. Blankenship, Louisville
Mrs. Arthur R. Kasey, Louisville
Mrs. Carlisle Morse, Louisville
Tellers.....Mrs. A. S. Holmes, Corbin
Mrs. Roy Sanders, Dorton
Mrs. James Willoughby, Bowling Green
Pages.....Mrs. J. Douglas Adams, Prestonsburg
Mrs. James R. Flautt, Louisville
Mrs. Eli J. George, Lebanon
Time Keepers.....Mrs. Douglas E. Scott, Lexington
Mrs. Robert A. Stewart, Ashland

ADVISORY COMMITTEE

J. Andrew Bowen, M.D., Louisville
Jesse T. Funk, M.D., Bowling Green
Coleman C. Johnston, M.D., Lexington

IMMEDIATE PAST PRESIDENTS

Mrs. Earl W. Roles, Louisville
Mrs. Guy Morford, Owensboro
Mrs. James Sears Rich, Lexington

DISTRICT COUNCILORS

1st—Mrs. Walker M. Turner, Paducah
2nd—Mrs. John A. Logan III, Sebree
3rd—Mrs. George F. Brockman, Greenville
4th—Mrs. Lyman S. Hall, Campbellsville
5th—Mrs. Carlisle Morse, Louisville
6th—Mrs. Daryl P. Harvey, Glasgow
7th—Mrs. Carl Cooper, Jr., Bedford
8th—Mrs. Paul S. J. Kappes, Ft. Thomas
9th—Mrs. Mitchel B. Denham, Maysville
10th—Mrs. George C. Reed, Versailles
11th—Mrs. Arch B. Clark, Richmond
12th—Mrs. Morris Holtzclaw, Somerset
13th—Mrs. Joseph E. Stephenson, Ashland
14th—Mrs. Lloyd M. Hall, Salyersville
15th—Mrs. Samuel M. Adams, London
Co-Ordinator for Members-at-Large—Mrs. Richard E. Davis, South Carrollton

COMMITTEE CHAIRMEN

American Medical Education & Research Foundation.....Mrs. Robert C. Long, Louisville
Benevolence.....Mrs. Jesse T. Funk, Bowling Green
Blue Grass News, Editor.....Mrs. Marvin A. Lucas, Louisville
Co-Editor.....Mrs. Earl W. Roles, Louisville
Bulletin.....Mrs. Barton L. Ramsey, Somerset
By-Laws.....Mrs. C. Melvin Bernhard, Louisville
Cancer.....Mrs. Joseph Parker, Lexington
Civil Defense.....Mrs. J. Andrew Bowen, Louisville
Community Service..Mrs. Charles F. Wilson, Pikeville
Convention.....Mrs. William C. Durham, Louisville
Doctor's Shop.....Mrs. Stuart P. Hemphill, Danville
Finance.....Mrs. David M. Cox, Louisville
Health Careers.....Mrs. Hoyt D. Gardner, Louisville
Co-Chairman.....Mrs. A. S. Holmes, Corbin
Heart.....Mrs. Carl Shroat, Frankfort
Historian.....Mrs. Charles B. Johnson, Russell
International Health Activities.....Mrs. Paul E. Lett, Lancaster
Legislation.....Mrs. J. L. Stambaugh, Lexington
Co-Chairman....Mrs. W. C. Cloyd, Richmond
McDowell House.....Mrs. Walker Owens, Danville
Mental Health....Mrs. R. Glenn Greene, Owensboro
Nominations.....Mrs. James Sears Rich, Lexington
Past Presidents.....Mrs. James Sears Rich, Lexington
Program.....Mrs. George P. Archer, Prestonsburg
Publicity.....Mrs. Walter S. Coe, Louisville
Reports.....Mrs. W. Procter Eubank, Louisville
Rural Health.....Mrs. C. Dana Snyder, Hazard
Safety.....Mrs. Dwight Blackburn, Berea
Tuberculosis.....Mrs. James Harris, Paducah

PAST PRESIDENTS

*1923—Mrs. Graham Lawrence, Shelbyville
*1924—Mrs. Graham Lawrence, Shelbyville
*1925—Mrs. Van Albert Stilley, Benton
*1926—Mrs. Van Albert Stilley, Benton
*1927—Mrs. William M. Martin, Harlan
*1928—Mrs. James Thomas Reddick, Paducah
1929—Mrs. P. E. Blackerby, Louisville
1930—Mrs. E. B. Houston, Murray
*1931—Mrs. George A. Hendon, Louisville
1932—Mrs. Arthur T. McCormack, Louisville
*1933—Mrs. Bartlett K. Menefee, Covington
*1934—Mrs. Joseph L. Greenwell, New Haven
1935—Mrs. Luther Bach, Florence

Continued on Page 731

ORGANIZATION SECTION

Health-O-Drama to be Feature of 1964 Kentucky State Fair

The Kentucky State Medical Association will participate again this year in the Health-O-Drama Section at the 1964 Kentucky State Fair, September 11-19. Health-O-Drama, a "Health Fair" within the State Fair, was first presented during the 1962 State Fair.

It initially met with outstanding success and has become a main attraction at the Fair. It is sponsored by the Kentucky Council on Allied Medical Services, composed of KSMA, the Kentucky Dental Association, the Kentucky Nurses' Association, and the Kentucky Pharmaceutical Association.

Over 20 exhibits are annually presented in the Health-O-Drama Section by the allied health organizations. This year, KSMA will present an exhibit on seatbelts and an exhibit on the new Emergency Medical Identification Symbol.

Other features of Health-O-Drama include free services to the Fair patrons such as Glaucoma screening and Pulmonary Function Testing. If you attend the State Fair this year, you are urged to visit Health-O-Drama and the KSMA exhibits.

Ky. Pharmacists Elect Officers At July French Lick Meeting

Kentucky pharmacists elected Julius T. Toll, South Fort Mitchell, as president of the Kentucky Pharmaceutical Association during the three day annual meeting of the KPA at French Lick, Ind., July 27, 28, and 29. He succeeds R. W. Leake, Danville.

Featured speakers for the full program included J. Marvin Dodson, Ph.D., executive secretary of the Kentucky Education Association, and Max Eggleston, past president of the Iowa Pharmaceutical Association.

Other officers named for the 1964-65 associational year included: vice-presidents John Oehlschlaeger, Jr., Paducah, Thomas Weisert, Louisville, and Charles R. Hensley, Bowling Green; Secretary, E. M. Josey, Frankfort, and Treasurer Maxwell A. Schulten, Louisville. For the first time in its history, the Pharmaceutical Association elected a woman as chairman of its Board of Directors; Mrs. W. A. Feiler, Paducah, will serve in that office.

mock plane crash, acted by 150 Boy Scouts, Explorer Scouts and Red Cross Volunteers, were "treated" first by first-aid teams and then sent to various Louisville-area hospitals for further treatment. Police, firemen, and Red Cross workers assisted in the operation.

Dr. McPheeters Resigns Post As Mental Health Head

Harold L. McPheeters, M.D., Commissioner of mental health for Kentucky for nearly eight years, resigned his post July 24 to accept a similar position with the New York State Department of Mental Hygiene, according to an announcement by Governor Edward T. Breathitt.



Doctor McPheeters, a native of New York, graduated in 1948 from the University of Louisville School of Medicine and completed his psychiatric residency there. He is an associate professor of psychiatry at the University.

A member of the KSMA Mental Health Committee, Doctor McPheeters is a past president of the Kentucky Psychiatric Association and a former officer of the National Association of State Mental Health Program Directors.

AMA Disaster Care Meeting Held in Louisville

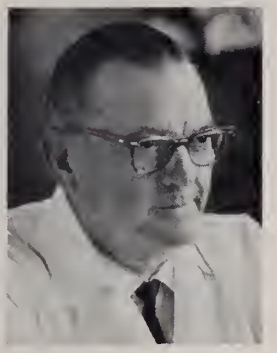
Approximately 70 persons attended a two-day regional meeting and workshop of the American Medical Association Committee on Disaster Medical Care at Stouffer's Louisville Inn on July 24 and 25. The group met in Louisville at the invitation of William T. Rumage, Jr., M.D., Louisville, chairman of KSMA Disaster Care Committee and a member of the AMA Committee.

Participating were physicians, and representatives of the AMA Woman's Auxiliary, the American Hospital Association, the American National Red Cross, Federal Civil Defense officials, and medical and lay representatives of medical associations and medical schools in the 11 states comprising Civil Defense Regions Two and Four.

"Operation Avalanche," a test of Louisville's disaster plans, was conducted in conjunction with the meeting by the Louisville and Jefferson County Office of Civil Defense, on Saturday, July 25. Victims of a

Automotive Medical Association To Meet in Louisville

The Amercian Association for Automotive Medicine will hold its annual meeting this year at Stouffer's Louisville Inn October 26-27, according to an announcement by William K. Keller, M.D., Louisville psychiatrist and president of the AAAM.



Sixteen guest speakers, including a chief of police, a lawyer, a general practitioner, an orthopedist, a professor of anatomy and a commissioner of public safety, will participate in the scientific sessions offered on the program, which is sponsored by the University of Louisville School of Medicine.

The association, formed in 1957 by a group of physicians interested in reducing the terrific toll of deaths and maiming by automobile accidents, now numbers over 200 members. Arthur H. Keeney, M.D., Louisville, chairman of the Kentucky State Medical Association's Highway Safety Committee, is secretary of the group.

The meeting, which will take place during the fall race meeting at Churchill Downs, will offer, in addition to an exciting scientific program, an opportunity for a relaxing visit to Louisville. Ladies are especially invited. Reservations should be made directly with Stouffer's Louisville Inn, Louisville, Ky. 40202.
Annual Meeting Section

Medical School News

Dr. Parks Is New Chairman Of U.K. Anatomy Dept.

Harold F. Parks, Ph.D., currently professor of zoology at Cornell University, Ithaca, N.Y., has been named new chairman of the department of Anatomy of the Colleges of Medicine and Dentistry at the University of Kentucky, succeeding William Knisely, Ph.D., who resigned last fall.

Doctor Parks, a native of Illinois, graduated from Southern Illinois University and did graduate work in musicology at Cornell before earning his Ph.D. in zoology from Cornell.

Richard S. Schweet, Ph.D., was selected to head the newly created department of Cell Biology of the Colleges of Medicine and Dentistry at U.K. Doctor Schween received his bachlor's degree from the College of the City of New York and his Ph.D. from Iowa State College in 1950.

U.K. Receives Large Grants

An initial grant of $100,139 from the United States Public Health Service for the study of chronic lung diseases has been awarded to the University of Kentucky Medical Center. The grant provides renewable support totaling more than $750,000 for a seven year period, according to Jerome E. Cohn, M.D., associate professor of medicine and director of the pulmonary division, who is principal investigator for the program.

Training grants providing $57,515 a year, renewable for five years, by the U.S. Public Health Service to the department of Behavioral Science at the U.K. Medical Center. The money is for support of a training program for medical, dental, and nursing students and students in other specified areas of study.

"Outstanding Instructors" Chosen

Lois A. Gillilan, M.D., professor of anatomy, was chosen the "Outstanding Pre-Clinical Instructor" by the sophomore medical students of U.K.'s Student American Medical Association chapter. Doctor Gillilan received a 'Golden Apple' placque; the first placque was presented last year to Tihamer Z. Csaky, Ph.D., chairman of the department of Pharmacology.

The first "Outstanding Clinical Instructor" award was presented following U.K. Commencement exercises to Charles B. Wilson, M.D., assistant professor of neurosurgery, by Richard Geist, M.D. on behalf of the senior members of SAMA.

U.K. Lists Faculty Appointments

The Board of Trustees of the University of Kentucky recently announced the following faculty appointments in the College of Medicine:

Apostolos Apostolopoulos, Ph.D., assistant professor of biochemistry; Munevver Bertan, M.D., instructor of community medicine; Thomas D. Brower, M.D., professor and head of division of Orthopedics; David L. Bruce, M.D., instructor of anesthesiology; James M. Chase, Jr., M.D., instructor of clinical surgery; and Eric Pfeiffer, M.D., instructor of clinical psychiatry.

Others are: Warren H. Proudfoot, M.D., instructor of clinical surgery; Robert R. Siegel, M.D., assistant professor of medicine; William B. Snyder, M.D., instructor of clinical surgery; and Paul M. Weeks, M.D., instructor of surgery.

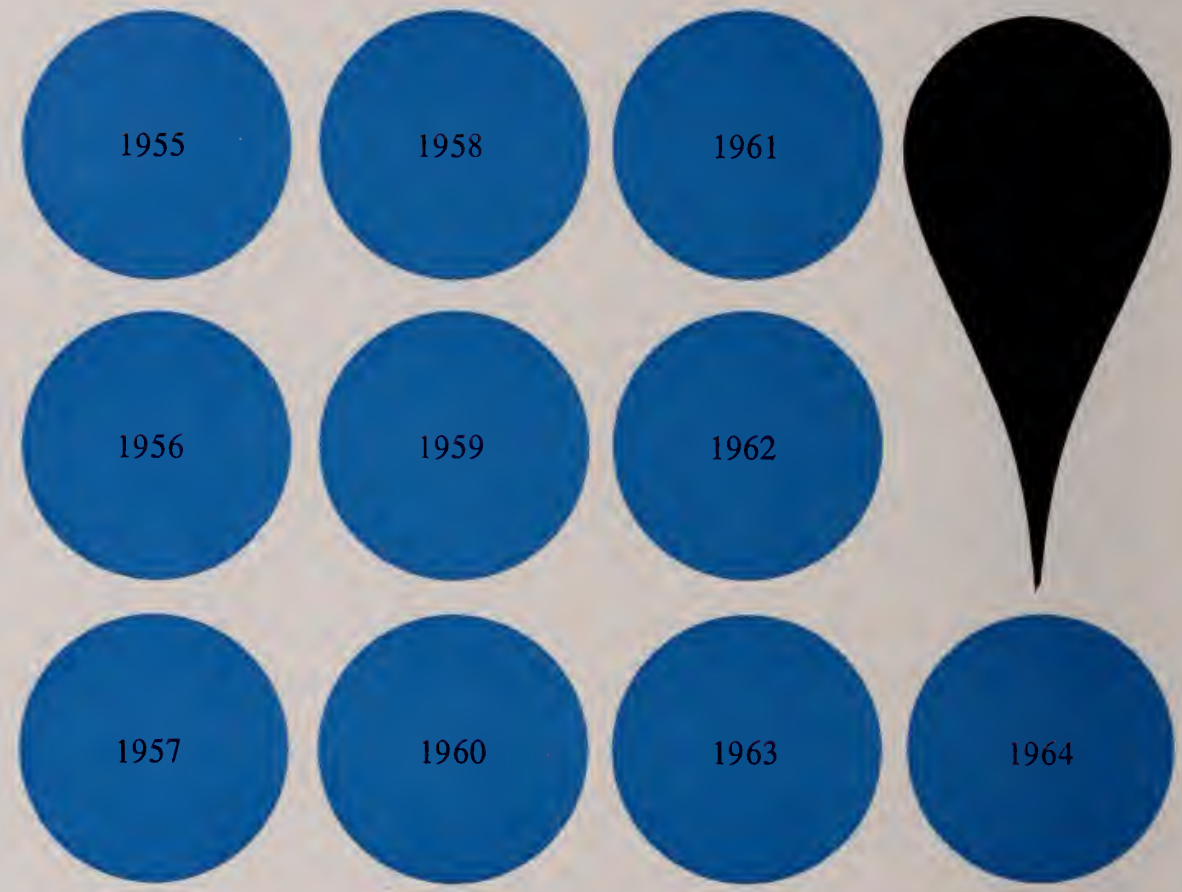
KAGP Has Two-Day Seminar At Cumberland Falls

More than 50 general practitioners, some accompanied by their wives and families, registered for the Cumberland Valley Seminar of the Kentucky Academy of General Practice at DuPont Lodge, Cumberland Falls, July 22 and 23.

Among the attractions of the meeting was the "Old South" Barbecue served by Raymond Sanders, M.D., Williamsburg, to more than 125 people on Wednesday evening. Speakers from Somerset, Corbin, Louisville and Lexington were on the scientific program arranged by Elmer G. Prewitt, M.D., Corbin. The program was approved for ten credit hours by the AAGP and was made possible by an educational grant from Eli Lilly and Company.

E. C. Seeley, M.D., London, KAGP president, presided at the Wednesday evening meeting of the Board of Directors, where it was decided to meet again at Cumberland Falls in 1966.

The clear conclusion from 10 years' experience...



belongs in every practice

Miltown®
(meprobamate)

WALLACE LABORATORIES/Cranbury, N. J.

CM-2026

KSMA Council And Committee Reports

SCIENTIFIC EXHIBITS COMMITTEE

Benjamin B. Jackson, M.D., Louisville, Chairman

KSMA Headquarters Office **July 15, 1964**

The KSMA Scientific Exhibits Committee selected the scientific exhibits to be presented at the 1964 KSMA Annual Meeting during their meeting on July 15. It was announced that all exhibits are to be in place by 8:00 a.m., Tuesday, September 29, and are not to be removed until 3:30 p.m., Thursday, October 1. Appropriate badges will identify each Scientific exhibitor who has agreed to man his booth for discussion and to provide pertinent literature.

The committee members approved the presentation of certificates to all exhibitors. A special committee will judge the exhibits and a plaque will be presented to the first-place winner.

COUNCIL ON MEDICAL SERVICES

W. Vinson Pierce, M.D., Covington, Chairman

KSMA Headquarters Office **July 2 & 30, 1964**

The Council on Medical Services met on July 2 and again on July 30. At its first meeting, a statement of the duties of the committees serving under the Council were approved and Council action was taken on the final reports of the committees. A report of a special "Appalachian Workshop" meeting was presented.

On July 30, the Council held a special meeting to discuss the various health-care programs being conducted in Kentucky. A detailed report on this meeting will be presented with the Council's recommendations to the 1964 meeting of the KSMA House of Delegates.

COUNCIL ON COMMUNICATIONS AND PUBLIC SERVICE

N. Lewis Bosworth, M.D., Lexington, Chairman

KSMA Headquarters Office **July 16, 1964**

The Council on Communications and Public Service held its second meeting of the year on July 16. Members of the Council approved KSMA exhibits for the 1964-65 Associational year, but recommended that KSMA not present an exhibit at the 1965 meeting of the Kentucky School Boards Association meeting due to the lack of interest.

The concept of Community Health Week, October 18-24, was approved, and a tentative program for the KSMA Orientation Course was acted on favorably by the Council. The Council members recommended that the first KSMA Orientation Course be held on Monday preceeding the 1965 Annual Meeting. The reports of the committees serving under the Council were reviewed and received Council action.

COUNCIL ON ALLIED PROFESSIONS AND RELATED GROUPS

W. Donald Janney, M.D., Covington, Chairman

KSMA Headquarters Office **July 9, 1964**

The KSMA Council on Allied Professions and Related Groups met on July 9 and approved a statement of the duties for the committee serving under the Council. Members of the Council discussed in detail the activities conducted by the committees during this past year and took action on the final reports of the committees.

Dr. Simpson Re-Appointed

Gaithel L. Simpson, M.D., Greenville, was recently reappointed by Kentucky Governor Edward T. Breathitt to a four-year term as chairman of the Governor's Advisory Council on Indigent Care.

Doctor Simpson, KSMA president in 1961-62, just completed a four year term as chairman of the committee.

Dr. Teague Heads AMA Committee

Russell E. Teague, M.D., Commissioner of health for the Commonwealth of Kentucky, was appointed chairman of the Section on Preventive Medicine of the American Medical Association at the AMA Annual Meeting in San Francisco in June. Until his appointment, Doctor Teague had served as vice-chairman of the Section.

TV Surgery on SMA Program

Cateract and Strabismus surgery will be televised live this year at the scientific session of the Section of Ophthalmology of the Southern Medical Association at the SMA Annual Meeting in Memphis November 16-19. Moderator of the entire television program will be Philip M. Lewis of Memphis, vice-chairman of the Section.

The surgery will be performed by James W. McKinney, M.D., Ralph S. Hamilton, M.D., and Daniel F. Fisher, M.D., all of Memphis. Distinguished panelists for the program are William B. Clark, M.D., New Orleans; Dupon Guerry, III, M.D., Richmond; and Louis J. Girard, M.D., Houston. The remainder of the scientific program will be announced soon. For additional information, contact George S. Ellis, M.D., 812 Maison Blanche Building, New Orleans, La.

Remember to Renew Vaccination

Surgeon General Luther L. Terry, of the U.S. Department of Health, Education, and Welfare, has recommended that persons who meet and treat the sick, as well as those working around international seaports, airports, and land border points of entry to the United States, be vaccinated against smallpox at least every three years and preferably every year.

The re-immunization program is suggested to increase and maintain at a high level the protection against smallpox of those persons most likely to have contact with an infected international traveler.

too young to be so tired...





revive interest... restore activity promptly with

AlerTonic®

Three tablespoonfuls (45 cc.) contain:		
Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molyhdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age

Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ... available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio / Weston, Ontario

Dr. Johnson, Ex-Senator, Dies

Joseph Elbert Johnson, M.D., 70, 1958 recipient of the KSMA Distinguished Service Medal and a former State senator, died early last month at his home in South Williamson. He had practiced general medicine in that area since 1924.

Doctor Johnson, who served for 10 years in the State Senate, graduated in 1921 from the University of Louisville School of Medicine. He was a veteran of World War I and a former member of the Pike County School Board.

Dr. Giannini Returns Winnings

When J. Thomas Giannini, M.D., Louisville, returned his $1,000 Hole-in-One Contest winnings to the Downtown Kiwanis Club of Louisville at the regular July 29 meeting of the Club he received a standing ovation.

The contest is held annually by the club for the benefit of its Underpriviledged Childrens' program. Doctor Giannini told the Kiwanians that because of his own interest in this important work, he would like the full amount of his winnings applied to the program.

Pan-Pacific Seminar Tour Set

The Pan-Pacific Surgical Association has announced that the Tenth Congress of the Association and the Second Mobile Educational Seminar will be held in three parts beginning September 20 and ending November 1, 1964. All physicians are invited to attend.

The Congress will convene in Honolulu on September 20 at the Princess Kaiulani Hotel. Part II, beginning September 28, will be held in Japan and Hong-Kong, and Part III will continue on to the Philippines, Thailand, India, Singapore, Australia and New Zealand. For further information, write: Pan-Pacific Surgical Association, Room 236, Alexander Young Building, Honolulu, Hawain 96813.

New Hospital is Fair Feature

The futuristic Atomedic Hospital (the name is derived from Atomic Age Medicine) dedicated June 23 for use as an emergency hospital at the New York World's Fair, is the embodiment of a new concept developed to provide better medical care at sharply reduced costs.

The unique unit, which employs such revolutionary concepts as electronic control of airborne contaminants and continuous electronic monitoring of patients' vital body functions, was conceived for use in small communities as well as other suitable areas. Because of reduced construction, maintenance, and operating costs, such hospitals could be the answer to the problem of providing hospital facilities in communities not otherwise able to afford hospitals. Tours can be arranged at the Fair for medical and allied professional groups.

County Society Reports

MUHLENBERG

At the regular meeting on August 3, the Muhlenberg County Medical Society adopted a resolution for submission to the House of Delegates of the Kentucky State Medical Association, requesting that the House again express opposition to the extension of Social Security coverage to self-employed physicians.

James Brashear, M.D., Greenville, presented "An Economic Analysis of Physician-Owned Professional Office Buildings" following the scientific program.

Congress on Strokes Set in Oct.

The First National Congress on Strokes will be held at the Palmer House in Chicago, October 29-31. The program, which will be conducted by an outstanding faculty, will constitute an intensive course on pre-stroke detection, preventive medical and surgical techniques, medical care of the acute stroke patient, and continuing convalescent care.

Sponsoring agencies for this national congress on one of America's major medical problems are the American Medical Association, Heart Disease Control Program of the U.S. Public Health Service, and the Vocational Rehabilitation Administration of the Department of HEW.

Pertinent Paragraphs

"Current Advances in Arthritis and Related Diseases" will be the topic of the Cleveland Clinic's October 7 and 8 postgraduate course to be held in Cleveland. Further information may be obtained by writing to The Cleveland Clinic Educational Foundation, 2020 East 93rd St., Cleveland, Ohio, 44106.

A symmposium in "Occupational Skin Problems" will be presented October 12-15 for industrial physicians at the Kettering Laboratory, Cincinnati, by the department of Preventive Medicine and Industrial Health of the University of Cincinnati. Application must be made before September 25; a registration fee will be charged. For application form and program, write to: Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda, Cincinnati, Ohio 45219.

"Modern Concepts of Nutrition and Heart Disease" will be the subject of a postgraduate course to be cosponsored by the Mound Park Hospital, St. Petersburg, Fla., and the American Academy of General Practice October 22-24 at the hospital. The AAGP will allow 18 Credit Hours in Category 1. For additional information, contact M.A. Barton, M.D., President, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla.

The Cleveland Clinic Foundation will present a postgraduate course entitled "Advances in Anesthesiology" at Cleveland September 17 and 18. Information may be obtained by writing to the Foundation at 2020 East 93rd St., Cleveland 6, Ohio.

ANY PAIN

not severe enough to require morphine is an indication for

'Empirin'® Compound with Codeine



'EMPIRIN' COMPOUND with CODEINE No. 3
KEEPS THE PROMISE OF PAIN RELIEF

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

The KENTUCKY HOTEL is proud
for the KENTUCKY STATE

No men in this entire State work under more strain or pressure than the members of the Kentucky Medical Profession.

No men are of greater VALUE to all the people of this Commonwealth.

Hence, during the endless hours of their "work days," and during their few priceless minutes outside their professional duties, Doctors DESERVE the utmost in comfort, convenience and friendly service, in the hotels and restaurants they patronize.

to be HEADQUARTERS
MEDICAL ASSOCIATION

Under the circumstances, the Kentucky Hotel is more than proud of the fact that we have been chosen as HEADQUARTERS for the Kentucky State Medical Association—not only during Convention-time, but EVERY DAY OF THE YEAR.

We feel that we owe you not only our best "hospitality," but also our deepest respect and our warmest friendship. And, in some cases, our lives . . .

For all these reasons, now and always—WELCOME TO KENTUCKY HOTEL.

RECOGNIZE THIS PATIENT?



"The arthritis doesn't get any better... I can't get out. I never see anybody. It's awful to be sick... I was always so active."

When you recognize depression and anxiety related to an organic condition
—*add 'Deprol' to your therapy*

Typical organic conditions in which 'Deprol' helps control related depression and anxiety:

cardiovascular disorders ■ arthritis ■ cancer ■ menopause ■ alcoholism ■ obesity ■ asthma, hay fever and related allergies ■ chronic infectious diseases ■ dermatoses ■ G.I. disorders, and many other debilitating or life-threatening illnesses

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' relaxes physical tensions, restores normal sleep and revives interest in food.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is compatible with drugs used to treat co-existing organic conditions.
5. 'Deprol' is relatively nontoxic and free of side effects.

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 tablet t.i.d. or q.i.d. May be increased gradually, as needed, to 6 tablets daily. With establishment of relief, may be gradually reduced to maintenance levels. **Supplied:** Light-pink, scored tablets Bottles of 50.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-801

News Items

Marion F. Beard, M.D., Louisville internist, delivered a paper on "Vitamin B_{12} Antagonists in the Human" at the Tenth Congress of the International Society of Haemotology at Stockholm, Sweden, on September 1.

Robert Sory, M.D., Richard, was presented a gold pion and lifetime membership card by the Grand Masonic Lodge of Kentucky on July 23 at a fish fry in his honor given by the Richmond Lodge. Doctor Sory, a retired Richmond physician, has been a Mason for 50 years.

L. F. Beasley, M.D., Franklin, is the proud owner of Henslee Farms V. Loyal, a registered Guernsey bull recently named a Summarized Sire by the American Guernsey Cattle Club. To attain this rating, a bull must have at least 10 daughters with official production records. Doctor Beasley has been a cattleman for a number of years.

Carroll L. Witten, M.D., Louisville general practitioner, has been appointed to the Surgeon General's Advisory Committee on Indian Health. The appointment is for four years. Doctor Witten is president-elect of the Kentucky Academy of General Practice.

Keath Hammon, M.D., Louisville, won both the West Kentucky Championship and the Jackson Purchase Open Skeet titles for the second year in a row at the annual shooting event at Mayfield July 19. Doctor Hammon also took high overall gun honors, won the .28 gauge championship, and was runner-up in the .410 division.

Gant Gaither, M.D., Hopkinsville, 1956 president of KSMA, will be honored by his hometown by having a $1.6 million dollar addition to Jennie Stuart Hospital named for him. Doctor Gaither, a surgeon, practiced in the Christian County area from 1912 until his retirement in 1956. He performed the first surgical operation at Jennie Stuart Hospital after it opened in 1914.

David M. Greeley, M.D., formerly associated with the UMW Hospitals in Eastern Kentucky, has become associate director of the Educational Council for Foreign Medical Graduates at Evanston, Ill., it was recently announced.

Sam B. Nunnelly, M.D., Hebron, was honored July 11 when the Hebron Lion's Club held open house and a 'Then and Now' biographical sketch of his life in recognition of his 55 years of practice in Boone County. A native of Somerset, he graduated in 1909 from the Medical Department of the University of Louisville.

Roy L. Clemons, M.D., is associated with Joe E. Carter, M.D., in general practice in Louisa. Doctor Clemons graduated from the University of Louisville School of Medicine in 1963 and interned at Tampa General Hospital.

Philip VanDeventer, M.D., has started general practice at Hopkinsville, where he will share the offices of **U. L. Fisher, M.D.** He is a 1961 graduate of the University of Cincinnati School of Medicine and interned at Charity Hospital in New Orleans. Doctor Van Deventer served for two years with the U.S. Public Health Service.

Terrell D. Mays, M.D., is now in general practice at Earlington, and is associated with the Trover Clinic. A 1963 graduate of the University of Louisville School of Medicine, he interned at Parkland Memorial Hospital in Dallas.

John M. Hall, M.D., Scottsville, has resumed general practice in that city in association with **O. L. Davis, M.D.** Doctor Hall previously practiced at Scottsville for one year before entering the U.S. Army in 1962. He is a 1961 graduate of the University of Louisville School of Medicine and interned at The Medical Center, Columbus, Ga.

A. V. Wilwayco, M.D., a native of the Philippines, is now practicing in association with **Carter Moore, M.D.,** in Franklin. He will limit his practice to surgery. A graduate of the University of St. Thomas in Manila in 1955, he interned at Jewish Hospital, Cincinnati, Ohio, and took his residency training at Reading Hospital, Reading, Pa.

Billy H. Wells, M.D., has started general practice in Corbin after a year of practice in his hometown, Albany. A 1962 graduate of the University of Louisville School of Medicine, Doctor Wells interned at the Guthrie Clinic and Robert Packer Hospital in Sayre, Pa.

William Thomas Watkins, M.D., is practicing pediatrics in association with R. N. McLeod, M.D., and Thomas Wilson, M.D., in Somerset. After graduating from the University of Tennessee Medical School in 1960, he interned at Boston City Hospital, Boston, Mass., and took residency training there and at Children's Hospital, Cincinnati, Ohio.

MADISON, INDIANA—PSYCHIATRISTS AND GENERAL PHYSICIANS wanted in a fully accredited 1500-bed State Psychiatric Hospital, dynamically oriented, intensive and continued treatment programs. Salary Ranges, General Physicians $1200-$1475 per month. Psychiatric Physicians (3 years residency in Psychiatry or Neurology) $1400-$1675 per month. Psychiatrist (Board Eligible) $1500-$1775 per month. Psychiatrist (Board Certified) $1600-$1875 per month. Complete maintenance available for single or married applicants with families at a very reasonable rate. Apply to: Ott B. McAtee, M.D., Superintendent, Madison State Hospital, Madison, Indiana 47251

the problem: diabetic and overweight

the answer: "...if the [diabetic] patient is overweight...our first choice is phenformin [DBI], since this is the only oral hypoglycemic agent commercially available at present which does not promote fat deposit."[1]

"...with phenformin [DBI] there may be less preferential stimulation of fat synthesis in the obese, diet-resistant diabetic, favoring both blood sugar and body weight control."[2]



to manage the stable adult diabetic who is overweight

DBI® DBI-TD

tablets 25 mg. **timed-disintegration capsules 50 mg.**

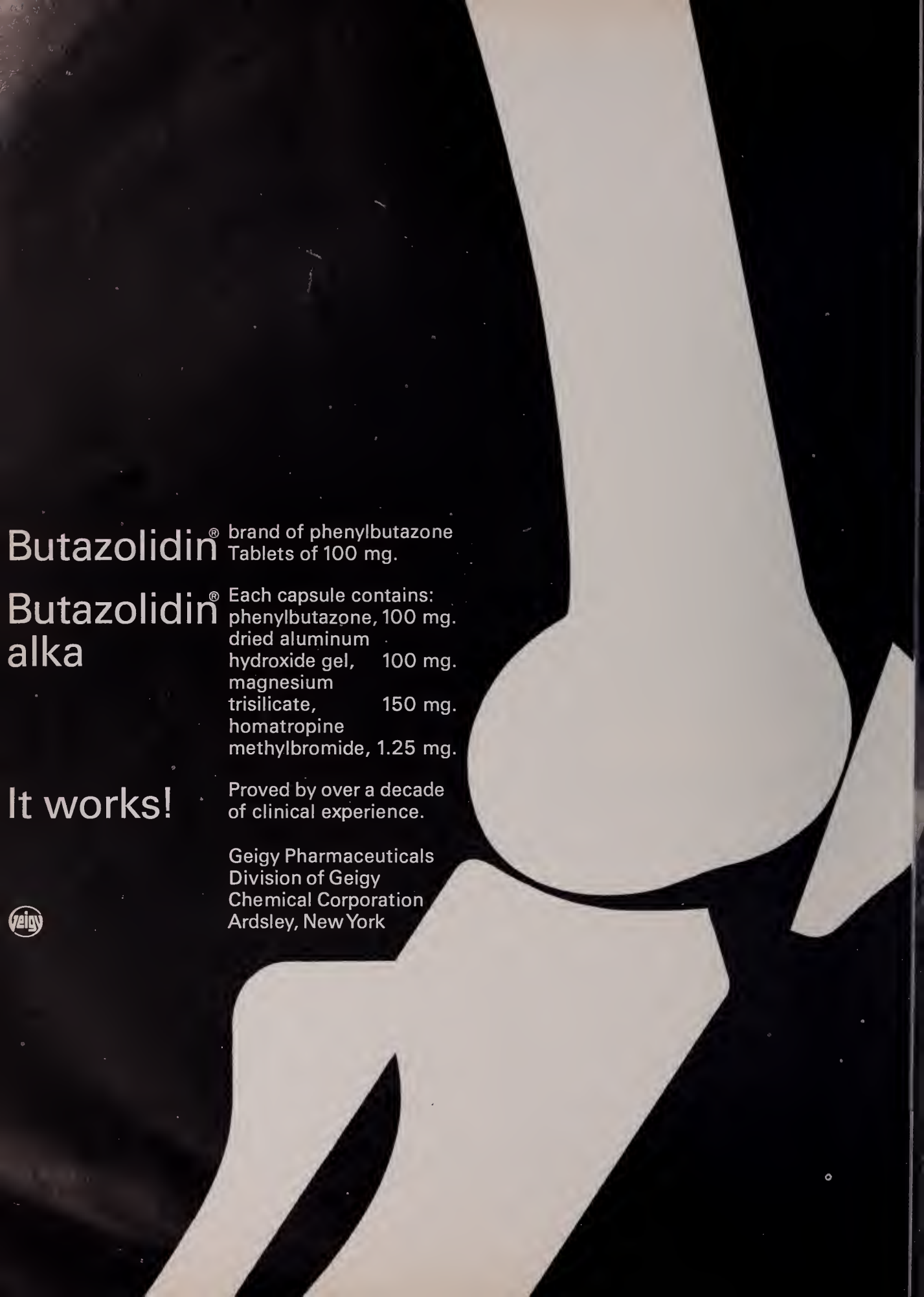
BRAND OF PHENFORMIN HCl

DBI together with a proper diet usually affords effective control in the overweight ketoacidosis-resistant diabetic... reduces high blood sugar and elevated serum insulin levels, and encourages gradual weight loss toward normal.

side effects: Gastrointestinal, occurring more often at higher dosage levels, abate promptly upon dosage reduction or temporary withdrawal. **precautions:** Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, and treated accordingly. Lactic acidosis has been reported in nondiabetics and diabetics treated with insulin, with diet, and with DBI. Question has arisen regarding possible contribution of DBI to lactic acidosis in patients with renal impairment and azotemia and also those with severe hypotension secondary to myocardial or bowel infarction. Periodic B.U.N. determinations should be made when DBI is administered in the presence of chronic renal disease. DBI should not be used when there is significant azotemia. Any cardiovascular lesion that could result in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **pregnancy warning:** *During pregnancy, until safety is proved, use of DBI, like other oral hypoglycemic drugs, is to be avoided.* Consult product brochure for full information.

1. Faludi, G.: J. Am. Med. Women's Assoc. 18,722, 1963. 2. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962.

U. S. VITAMIN & PHARMACEUTICAL CORP. • 800 Second Ave., New York, N.Y. 10017


Butazolidin® brand of phenylbutazone
Tablets of 100 mg.
Butazolidin® alka
Each capsule contains:
phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.
It works!
Proved by over a decade of clinical experience.
Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York
Geigy

COMMEMORATING ITS *90th Anniversary*

OF DEDICATED SERVICE IN THE FIELD OF PSYCHIATRY



'or almost a century, THE EMERSON A. NORTH IOSPITAL, Inc. has been the haven and hope for human eings distraught with nervous and mental disorders nd conflicts. Located away from the tensions of the utside world, situated on 40 acres of beautiful private tate grounds—this dedicated hospital offers complete sychiatric treatment and care:

every advancement in the field of psychiatry, proved therapeutic methods and the most modern procedures

services of an active medical staff composed of 20 psychiatrists, augmented by specialist - consultants from the major medical center of Cincinnati

- ample classification facilities and qualified psychiatric nursing
- full recreational therapy facilities
- conveniences and surroundings to assure the greatest comfort and most desirable benefits
- experience and knowledge gained in 90 years of successful operation
- approved by the Joint Commission on Accreditation of Hospitals

PAUL W. WATKINS, M.D.
Medical Director

ISABELLE DAULTON, R.N.
Director of Nursing

ELLIOTT OTTE
President

GRACE SPINDLER, R.N.
Associate Director of Nursing

Brochure and rate schedule available on request

THE *Emerson A North Hospital* INC.

(FOUNDED 1874)

5642 Hamilton Avenue, Cincinnati, Ohio 45224
Telephones: 541-0135, 541-0136

Oldest private psychiatric hospital west of Alleghenies and largest in state of Ohio



IN THE BOOKS

MEDICAL PHARMACOLOGY, Second Edition: by Andres Goth, M.D., published by The C. V. Mosby Co., St. Louis, Mo., 1964; 585 pages; Price, $11.75.

The avowed aim of the first edition of this book (which appeared in 1961) was to present current pharmacologic knowledge with particular reference to principles and concepts. It was written primarily for students and practitioners; it was undeniably a success, being the most popular text with medical students in the department of which this writer is chairman. The difficulty of the multiplicity of drugs was avoided by presenting the important drugs, mentioning their congeners but discussing only the differences between them and their prototypes. Thus a book of modest size was achieved, on which students could base their further growth.

The pace of development of pharmacology is such that a second edition was necessary in so short a time not only to present new drugs but also new concepts. Thus newer drugs such as antihypertensive agents, diuretics, antibiotics, are included and evaluated, and also new concepts of the metabolism and modes of action of drugs are given.

Chapters begin with a statement of general concept of a particular kind of drug action; there follows a discussion of the most important drugs in the group in detail; differences in action of the members of the group are given (structural formulas are enough but not too many). Evidence of drug safety and toxicity is offered, based on the results of controlled usage in man as well as data from laboratory animals. At the end of many chapters is a concise statement of the group of drugs in clinical pharmacology. Each chapter has one-half to two pages of references to the literature, keyed to statements in the text. Many references are as late as 1962.

In summary, this is a highly readable, well-documented, up-to-date textbook of pharmacology strongly recommended to all students and practitioners of medicine.

PETER K. KNOEFEL, M.D.

CURRENT PEDIATRIC THERAPY: Edited by Sydney S. Gellis, M.D., and Benjamin M. Kagan, M.D.; published by W. B. Saunders Company, Philadelphia, 1964. 747 pages; price, $16.00.

Current Pediatric Therapy is a final product of 248 outstanding contributing specialists whose larger experience in limited areas gives them extensive advanced knowledge. The book provides a personal approach and opinions of leading authorities who devote their efforts in keeping abreast of the most recent and complete information relative to the particular problems they discuss.

The editing authors stress that *Current Pediatric Therapy* is not intended to assist the physician in making a correct etiological diagnosis. Since the characteristics of disease vary little with time, the establishment of an etiological diagnosis is mandatory and in this situation the book is valuable to the physician who may use it quickly to obtain a detailed orientation to a currently practiced and accepted therapeutic approach. Since therapy in recent years has been rapidly changing, many accepted therapeutic measures are not listed in the text.

WALTON M. EDWARDS, M.D.

CANCER OF THE STOMACH: by William H. ReMine, M.D., James T. Priestley, M.D., and Joseph Berkson, M.D., and Members of the Mayo Clinic Staff; published by W. B. Saunders Co., Philadelphia and London, 1964; 255 pages Price, $11.50.

This recent monograph beautifully collects the experience of the Mayo Clinic in the surgical treatment of a most distressing disease. The book is highly readable and offers a complete current analysis of the present problems and past experiences in the treatment of gastric malignancies at the Mayo Clinic. Sections on anesthesia, pre- and postoperative care, and the pathologic anatomy seem a bit redundant and hardly justify their presence by any recent advances specifically related to this subject.

Unfortunately, the advances in the diagnosis, treatment, or understanding of carcinoma of the stomach have been rather modest during the past 20 years, so that the current work has little to report of a startling nature. However, past results allow a thorough analysis of standard procedures. The authors are particularly instructive to the surgeon in their evaluations of total gastrectomy versus extended subtotal gastrectomy. The value of a palliative subtotal gastrectomy versus a simple palliative drainage operation is well presented along with impressive clinical evidence to favor resection over drainage procedures.

The addition of newer improvements in diagnosis such as cytology, flexible gastroscopic techniques, gastric acid analysis and the more esoteric procedures including balloon autoradiography and tetracycline flourescence is discussed. These procedures seem to add little to the over-all problem.

A statistical evaluation of the experience at the Clinic during the 50-year period from 1907 to 1957, offers much information regarding decreasing frequency, improvements in operability, resectability, and survival rates as well as over-all survival. These figures demonstrate modest improvements in the care of this disease and are particularly important in their demonstration of the high curability of the early malignant ulcer.

In summary, this is a highly readable and informative book, but unfortunately offers little which will be new to anyone who has closely followed the recent literature in this area.

WILLIAM H. MARSHALL, M.D.



In Chronic Illness: B and C vitamins are therapy

An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS, containing therapeutic quantities of vitamins B and C, is formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

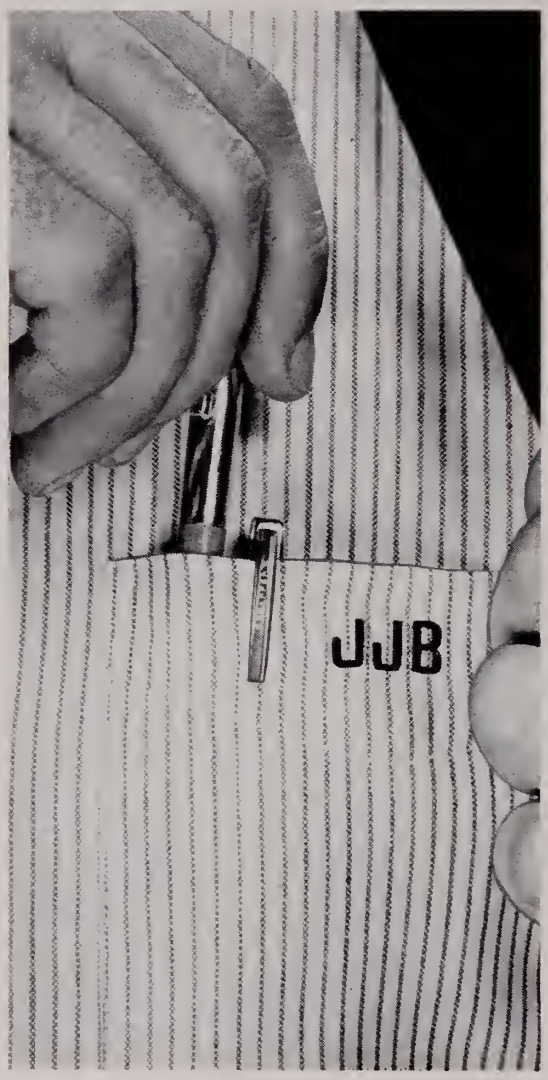
STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

7514-4



The most successful investments are those made in the most successful companies. It is not necessary to predict which companies will become successful; it is only necessary to compound the hindsight of recognizing success with the foresight of a willingness to pay for it.

J. J. B. HILLIARD & SON

• Louisville • Lexington • Owensboro • Hopkinsville
Bloomington • Columbus, Ind.

MEMBER New York Stock Exchange
MEMBER Midwest Stock Exchange
ASSOCIATE MEMBER American Stock Exchange

News Items

William C. Young, M.D., is now practicing in association with **Gabe A. Payne, M.D.,** at Hopkinsville, it was recently announced. Doctor Young, who will limit his practice to pediatrics, is a 1960 graduate of the Vanderbilt University School of Medicine, and completed both his internship and residency requirements at Vanderbilt.

Leif O. Torkelson, M.D., an internist, is a new member of the staff of the University of Kentucky Medical Center at Lexington. Doctor Torkelson, a 1957 graduate of the University of Virginia School of Medicine, interned at Mary Fletcher Hospital at the Medical College of Vermont, and completed his residency at Duke University affiliated hospitals.

James H. Sprouse, Jr., M.D., has joined the staff of the University of Kentucky Medical Center as an anesthesiologist. He graduated from the Medical College of South Carolina in 1957. Doctor Sprouse took his internship and residency training at Medical College Teaching Hospitals, Charleston, South Carolina. He was a surgeon with the U.S.P.H.S. in 1960-63 and is board certified in anesthesiology.

Bennett N. Asher, M.D., has opened an office at Winchester, where he will practice general medicine, it was recently announced. A 1961 graduate of the University of Louisville School of Medicine, Doctor Asher completed his internship at Wesley Hospital in Wichita, Kan., and recently ended a two year tour of duty with the U.S. Air Force.

George Cheatham, M.D., has begun general practice at Greensburg after completing his internship at Springfield City Hospital, Springfield, O. Doctor Cheatham is a 1963 graduate of the University of Louisville School of Medicine.

Paul W. Schaper, M.D., will practice general surgery at Benton, it has been announced. Doctor Schaper, who graduated in 1959 from the University of Missouri School of Medicine, interned and completed his residency at St. Louis County Hospital, St. Louis, Mo.

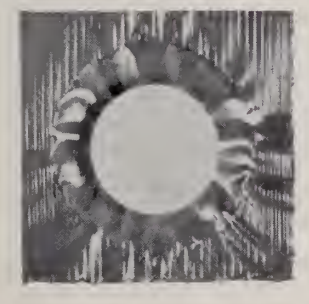
Murray F. Ables, M.D., Lexington, has joined the staff of the Veterans Administration Hospital in that city as staff psychiatrist. He is a 1960 graduate of the University of Wisconsin College of Medicine, and interned at City Hospital, Springfield, O. Doctor Ables was a resident at the Topeka, Kan., V.A. Hospital, and at the Menninger School of Psychiatry in Topeka.

Harry G. Caldwell, M.D., Louisville ophthalmologist who recently completed his residency at the University of Louisville hospitals, is currently serving in Jerusalem under the auspices of MEDICO, a service of CARE. Doctor Caldwell is a 1958 graduate of the University of Louisville School of Medicine.

GEL-KAM

THIS TABLET OFFERS 3 SIGNIFICANT ADVANTAGES THE NAME . . .

GEL-KAM



1. EFFECTIVE LONGER
Gel-Kam ingredient Dihydroxy Aluminum Aminoacetate maintains gastric pH between 3.5 and 4 for a significantly longer time than the corresponding dose of ordinary Aluminum Hydroxide.[1]

2. UNDISTURBED REGULARITY
Dihydroxy Aluminum Aminoacetate in combination with the other Gel-Kam ingredient does not cause constipation.[1]

3. PLEASANT TASTING
Smooth, non gritty, pleasant tasting Gel-Kam tablets melt or dissolve quickly. The patient can easily chew several Gel-Kam tablets if unusually large amounts of antacid medication are needed.

COMPOSITION: Each Table Contains: Dihydroxy Aluminum Aminoacetate . . . 4.7 gr. Magnesium Hydroxide . . . 3 gr. **DOSE:** One or two tablets 1 to 2 hours after meals and upon retiring, or as prescribed by the physician. **INDICATIONS:** Antacid and buffer for gastric hyperacidity and peptic ulcer. **CAUTIONS AND SIDE EFFECTS:** No significant contraindications exist to the use of Gel-Kam tablets, except that it should not obviate the need for other treatment and medical supervision in peptic ulcer. Packed in plastic strip. 100 tablets to a carton and 500 tablet bottles. Professional samples and literature available.

[1](Journal of Gastroenterology, Vol. 29, page 304)

FTP **First Texas *Pharmaceuticals, Inc.***
DALLAS • ATLANTA • SINCE 1901



- PETN (pentaerythritol tetranitrate) to increase oxygen supply
- plus meprobamate to decrease anxiety and tension

Unlike phenobarbital, meprobamate is *not* cumulative and does *not* cause depression.

Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. **Precautions:** Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. **Contraindications:** Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* **Dosage:** 1 to 2 tablets, *before meals* and at bedtime. Individualization required. **Supplied:** Bottles of 50 tablets.

CML-1055

MILTRATE®

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

News Items

Clifton D. Lamm, M.D., has opened an office at Smiths Grove, where he will practice general medicine. A 1962 graduate of the University of Tennessee College of Medicine, Doctor Lamm interned at Good Samaritan Hospital. He was in practice at Brownsville before going to Smiths Grove.

Airzzie W. Greene, Jr., M.D., has begun the practice of general medicine at Franklin, where he will be associated with **Fred D. Owens, M.D.** Doctor Green, a 1963 graduate of the University of Louisville School of Medicine, completed his internship in June at Mercy Hospital in Springfield, O.

Lewis Martin, M.D., Cadiz, has become associated with the Futrell Clinic in that city, where he will have a general practice. Doctor Martin, a graduate of the University of Louisville School of Medicine, recently completed his internship at Mercy Hospital in Springfield, O.

James B. Cox, M.D. has gone to Hopkinsville, where he will share the offices of **Jere C. Robertson, M.D.** for the practice of obstetrics and gynecology. A 1960 graduate of the University of Tennessee College of Medicine, Doctor Cox interned at St. Joseph Hospital in Memphis and was a resident at John Gaston and St. Joseph Hospitals in that city.

Richard C. Marohn, M.D., has joined the staff of the Federal Correctional Institution at Ashland. Doctor Marohn, a psychiatrist, is a 1960 graduate of Marquette University School of Medicine and interned at Milwaukee County Hospital, Milwaukee, Wis., before becoming a resident at Illinois State Psychiatric Institute, Chicago.

Robert H. Hyde, M.D., Winchester, has opened an office in that city for the general practice of medicine. Doctor Hyde, a 1963 graduate of the University of Louisville School of Medicine, interned at St. Elizabeth Hospital in Dayton, O.

Harry E. Voyles, Jr., M.D., has announced the opening of his office in Louisville, where his practice will be limited to internal medicine. Doctor Voyles, a 1958 graduate of the Indiana University School of Medicine, interned at Jefferson Medical College and the University of Louisville Hospitals. His residency was completed at Louisville General Hospital

Dover A. Dick, M.D., who formerly practiced at Berea, has moved and resumed his practice in Oxford, O., it was recently announced. Doctor Dick, a graduate of the University of Cincinnati, had been at Berea for two years.

Frank T. Varney, M.D., has opened an office at Stone, where he will maintain a general practice. A native of Stone, Doctor Varney graduated from the University of Louisville School of Medicine in 1963, and completed his internship at Floyd Hospital in Rome, Ga.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
203 Parkside Building, 4140 Shelbyville Road, Louisville 7
Mailing Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884

MT. HOLLY
NURSING HOME

A Nursing Home with Hospital Standards



- *24 Hour Personal, Medical and Nursing Care supplemented by Closed Circuit Television.*
- *Balanced and Therapeutic Diets.*
- *Facilities for Orthopedic, Geriatic and Medical Patients.*
- *Leisure time activities.*

MT. HOLLY NURSING HOME

OFF BROWNSBORO ROAD 897 - 1646

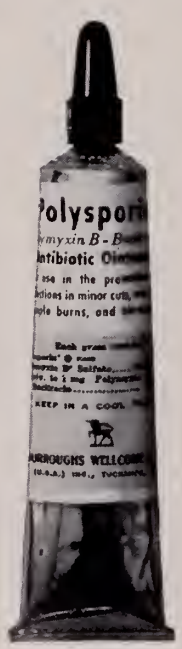


Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK (R)

---

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Contraindication:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: In ½ oz. and 1 oz. tubes
Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

A SYMPOSIUM ON INFECTIOUS DISEASES

November 11, 12, 13, 1964

To focus on selected problems in diagnosis, treatment and prevention of infections which may affect all ages within a family:

Enteric Viruses and Gram-negative Bacilli

Respiratory Viruses, Streptococci and Staphylococci

Histoplasma capsulatum and Atypical Mycobacteria

By the faculty of **Vanderbilt University School of Medicine**
assisted by the following distinguished visitors:

Dr. Dorothy Horstmann — Yale University

Dr. Warren E. Wheeler — University of Kentucky College of Medicine

Dr. George Jackson — University of Illinois College of Medicine

Dr. Floyd Denny — University of North Carolina School of Medicine

For Information write:

Director of Continuing Education
B-4211 Vanderbilt University School of Medicine
Nashville, Tennessee 37203

Registration Fee $60.00

NEW MEN'S SHOP



. . . in our **NEW SOUTHERN**
OPTICAL BUILDING, 640 S. 4th St., between
Broadway and Chestnut . . . where a man is king.
In its masculine surroundings, you'll experience
the same comfort while being fitted for
glasses as you do when being fitted for clothes.

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th



Answers To Questions About Your BLUE SHIELD

Q. What is Blue Shield's policy or procedure in explaining the subscriber's coverage at time of purchasing or proposing to group or individual?

A. *Group talks are given to all applicants whenever possible before enrollment, also individual interviews are held where permitted. Both benefits and exclusions are explained. Applicants are also furnished with descriptive literature and are issued subscribers' certificates of membership which explain benefits, exclusions and terms. Group leaders are called on regularly, receive training, and are furnished with a manual. Many non-group applicants have the Plan explained to them over the telephone, and all of them also receive descriptive literature. Exclusions are shown in red on all descriptive literature.*

Q. Explain on the new Blue Shield Service Reports what is wanted in the blank portions, and why.

A. *This is primarily for the patient's information, and is printed onto subscriber's copy attached to the claim form. This indicates the dates rendered of the various types of services for which payment is being made.*

Q. Are Blue Shield rates being increased?

A. *Some classes of groups are having an increase in dues due to high utilization. Blue Shield dues on direct pay members are not being increased at present.*

Q. Does a Blue Shield member lose his protection when he leaves a group?

A. *No. He is automatically billed at his home address of record, and may keep his protection by paying the quarterly dues.*

Q. What is a Blue Shield contract year?

A. *A contract year is the twelve months immediately following the Blue Shield anniversary date which is listed on the Identification Card. The maximums under Blue Shield are figured on a contract year basis and also the maximums under the Medical Rider are figured on a contract year basis.*

Q. I have recently been receiving some letters asking about length, depth, etc., in regard to lacerations. Why am I receiving these?

A. *In order to administer Blue Shield claims fairly, for the benefit of both patient and the physician, a complete description of lacerations and lesions is necessary. Pages two and three of the new Schedule C & D manual which has been sent all doctors explains the procedure used to determine payment on lacerations and lesions. Length and number of lacerations must be reported. Also, it is important to know whether the laceration required extensive debridement and if it were irregularly shaped.*

It is necessary to know the size, location, number and type in regard to lesions. Also, the method of removal (i.e., excision, fulguration, electro-cauterization, etc.) This procedure has been adopted in administering all schedules.

Q. Does Blue Shield cover newborn care?

A. *Some contracts provide protection from birth, others start at 30 days of age, depending upon type of coverage purchased by the subscriber.*

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator — MARGARET KELLY, R. N., Director of Nurses

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physio-therapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

The Modern Physician



must spend many hours keeping himself informed so that he may better serve his patients and his profession. Today, a doctor refers cases requiring special techniques to those trained in handling them.

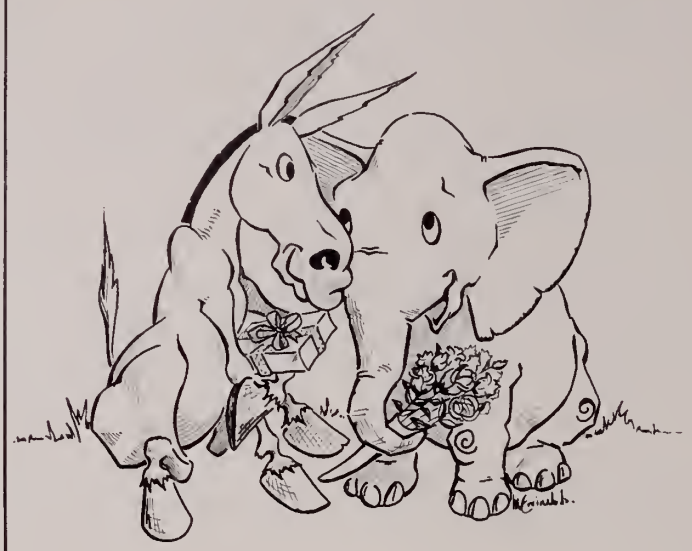
Just so, select your jeweler who must have training, experience and an established reputation for honesty and dependability. KENDRICK is such a jeweler, being a REGISTERED JEWELER of the AMERICAN GEM SOCIETY. Call on us at any time for expert advice and assistance in selecting quality gems. This service costs no more.

Kendrick Jewelers since 1832

MEMBER AMERICAN GEM SOCIETY

619 SO. FOURTH ST. — 584-5232

We're Getting Together



To Talk About

Politics

at the

Second Annual

KEMPAC Political Seminar

Please Join Us

Monday, September 28, 1964—Mirror Room, Kentucky Hotel

(First Day of the Kentucky State Medical Association Annual Meeting)

FEATURING: **Nationally-Known Speakers—**
Congressional Candidates for Kentucky Office—
AMPAC Chairman, Dr. Donald Wood—
And Many Other Leaders

Begins . . . . . **4:00 p.m.**
Social Hour . . . . . **6:00 p.m.**
Banquet . . . . . **7:00 p.m.**

TICKETS : $6.00

For Advance Tickets, write:

KENTUCKY EDUCATIONAL MEDICAL POLITICAL ACTION COMMITTEE
KEMPAC
3532 Janet — Louisville, Ky. 40205

Woman's Auxiliary Past Presidents

Continued from Page 703

*1936—Mrs. Ernest Arthur Barnes, Albany
*1937—Mrs. Stephen C. McCoy, Louisville
*1938—Mrs. Harlan Usher, Sedalia
1939—Mrs. Reasor T. Layman, Elizabethtown
1940—Mrs. John M. Blades, Butler
*1941—Mrs. John G. South, Frankfort
1942—Mrs. John B. Floyd, Richmond
1943—Mrs. Octavus Dulaney, Louisville
*1944—Mrs. Eleanor Hume Offutt, Frankfort
1945—Mrs. Shelby Carr, Richmond
1946—Mrs. Elmer L. Henderson, Louisville
1947—Mrs. Walker Owens, Mt. Vernon
1948—Mrs. R. Haynes Barr, Owensboro
1949—Mrs. Elbert W. Jackson, Paducah
1950—Mrs. Clark Bailey, Harlan
1951—Mrs. John S. Harter, Louisville
1952—Mrs. David Woolfolk Barrow, Lexington
1953—Mrs. Clyde C. Sparks, Ashland
1954—Mrs. Karl D. Winter, Louisville
1955—Mrs. R. Ward Bushart, Fulton
1956—Mrs. Charles B. Stacy, Pineville
1957—Mrs. J. Andrew Bowen, Louisville
1958—Mrs. Jesse T. Funk, Bowling Green
1959—Mrs. Charles B. Johnson, Russell
1960—Mrs. Earl W. Roles, Louisville
1961—Mrs. Guy Morford, Owensboro
1962—Mrs. James Sears Rich, Lexington

* *Deceased*

Dr. Chambliss Gets Intern Award

Robert B. Chambliss, M.D., Burkesville, was the 1964 recipient of the George P. Caldwell award presented annually to the Louisville Hospital intern showing the greatest proficiency of the year. The award was given at the annual alumni banquet of the U. of L. School of Medicine and General Hospital.

Doctor Chambliss, who completed his internship at General in April, is a participant in the Rural Scholarship Loan Fund Program and a graduate of the University of Tennessee College of Medicine.

Sterilization Project Begins

A program to alleviate poverty in 22 Eastern Kentucky Counties through voluntary sterilization of indigent parents, initially financed by a $25,000 grant from a New York philanthropist, was announced at a June 8 luncheon at Berea.

The pilot project is being carried out by the Human Betterment Association for Voluntary Sterilization, Inc. Louise G. Hutchins, M.D., Berea, will act as program coordinator.

Golden Anniversary Celebrated

Morris Fishbein, M.D., and Mrs. Fishbein, of Chicago, were honored by a Golden Wedding Anniversary celebration given for them by the Chicago Heart Association at the Sheraton-Blackstone Hotel, Chicago, on July 7. Doctor Fishbein is a co-founder of the Association and has devoted 42 years to heart research.

Doctor Fishbein, a former editor of The Journal of the American Medical Association, is well known as a medical lecturer and writer, and is still active in his profession.

IMPORTANT NOTICE FOR DOCTORS WITH PATIENTS IN CINCINNATI HOSPITALS

SOUTHERN ARMS 'Toothbrush Apartments'



DESIGNED EXPRESSLY FOR HOSPITAL OUT-PATIENTS AND MEMBERS OF FAMILIES WHO MUST BE NEAR A HOSPITALIZED PATIENT

Completely furnished and equipped — near all major hospitals

- SHUTTLE SERVICE TO ALL HOSPITALS
- ONE BEDROOM AND EFFICIENCIES
- AIR-CONDITIONED, FREE TV
- LINEN, EATING AND COOKING UTENSILS FURNISHED
- MAID SERVICE, NURSE ON CALL, RESIDENT MANAGER
- DAILY, WEEKLY, MONTHLY RATES

Tell your patients or their relatives to see these modern, convenient, new apartments, just minutes from all major hospitals.

621-6420

SOUTHERN ARMS 2058 Auburn Ave., at Southern Avenue

CINCINNATI, OHIO

In Memoriam

GERMAN POLK DILLON, JR., M.D.
Louisville, Ky.
1913 - 1964

German P. Dillon, Jr., M.D., 50, Louisville, past president of the Kentucky Society of Anesthesiologists, died August 16 in Louisville. After graduating from the University of Louisville School of Medicine in 1940, he did graduate work at Louisville General Hospital, Kentucky Baptist Hospital and Hartford, Connecticut, General Hospital. He was a partner of the late Dougal Dollar, M.D. and was widely known for his work in the field of anesthesiology.

LESLIE CHESTER DODSON, M.D.
Owensboro, Ky.
1900 - 1964

Leslie C. Dodson, M.D., Owensboro, a past president of the Daviess County Medical Society, died July 21 of cancer. A native of Daviess County, Doctor Dodson attended Harvard University School of Medicine, where he was awarded his M.D. degree in 1929. A surgeon, Doctor Dodson was a veteran of both world wars.

FRED WILLIAM RULANDER, M.D.
Louisville, Ky.
1908 - 1964

Fred W. Rulander, M.D., 55, Louisville surgeon and general practitioner, died late in July after a brief illness. Doctor Rulander, who graduated from the University of Louisville School of Medicine in 1932, was a member of KSMA, AMA, the Jefferson County Medical Society and a number of other medical groups.

OSCAR T. DAVIS, M.D.
Hopkinsville, Ky.
1918 - 1964

O. T. Davis, M.D., 44, Hopkinsville, died August 11 in Nashville. An internist, Doctor Davis had retired from active practice in recent years because of ill health. He was a 1943 graduate of Bowman Gray School of Medicine and had practiced in Owensboro until 1955 when he moved to Hopkinsville.

JOHN ROBERT NURSE, M.D.
Louisville, Ky.
1899 - 1964

John R. Nurse, M.D., 64, Louisville, died early last month at Red Cross Hospital, where he had been a staff member for many years. A 1925 graduate of Howard University School of Medicine, he was medical director of Mammoth Life and Accident Insurance Company. He was a veteran of World War I.

CHARLES ALVIN WOOD, M.D.
Auburn, Ky.
1900 - 1964

Charles A. Wood, M.D., Auburn general practitioner, died at his Christian County farm home Thursday, August 13. Doctor Wood, 63, was a native of Christian County and a graduate, in 1929, of the University of Louisville School of Medicine. He had practiced in Logan County since 1930.

GEORGE BARTON FROAGE, M.D.
Paducah, Ky.
1876 - 1964

George B. Froage, M.D., 88, Paducah's first pediatrician, died July 31 after more than a half century of practice in that city. Doctor Froage received his M.D. degree in 1919 from Kansas City Unviersity College of Physicians and Surgeons, Kansas City, Mo. He had done additional study in Chicago and other cities.

North Hospital Marks 90 Years

The Emerson A. North Hospital, Cincinnati, the oldest private psychiatric hospital west of the Alleghenies commemorating its 90th anniversary this year. Founded as the Cincinnati Sanitarium in 1874, the hospital was renamed for the late Emerson A. North, M.D., a distinguished psychiatrist, administrator, and educator in mental therapy.

WANTED:
MALE PSYCHIATRIST

OPENING FOR A BOARD ELIGIBLE OR BOARD CERTIFIED PSYCHIATRIST TO JOIN A WELL-ESTABLISHED GROUP.

IDEAL WORK CONDITIONS IN A 145-BED ACTIVE TREATMENT HOSPITAL SERVING SEVERAL SOUTHEASTERN STATES.

PROFESSIONAL FREEDOM. GOOD LIVING CONDITIONS.

Starting Salary - $20,000-25,000.

FOR FULL PARTICULARS
WRITE BOX 5 THIS JOURNAL.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

Lecture Series to Start at U.K.

Charles Aring, M.D., neurosurgeon from the University of Cincinnati School of Medicine, will be the first distinguished lecturer of the 1964-65 Distinguished Lecture series at the University of Kentucky Medical Center. Doctor Aring's presentation will be delivered October 8 at 8:00 p.m., beginning the monthly series.

IN KENTUCKY

SEPTEMBER

12	Internal Medicine, American College of Physicians, Joint Meeting of Kentucky and Tennessee, Louisville, Ky.
24-25	American College of Cardiology, Symposium on Operable Heart Disease, U.K. Medical Center, Lexington, Ky.
29-Oct. 1	KSMA ANNUAL MEETING, Convention Center, Louisville, Ky.

OCTOBER

8	KAGP Seminar, Maysville, Kentucky
8	Distinguished Lecture Series, University of Kentucky Medical Center, Lexington
8-10	Pediatric Course, "A New Look at Old Diseases", University of Kentucky Medical Center, Lexington
26-27	American Association for Automotive Medicine, Stouffer's Inn, Louisville, Kentucky
28	Postgraduate Course in Anesthesiology, General Hospital, Louisville

SURROUNDING STATES

SEPTEMBER

9-12	International College of Surgeons, Chicago, Ill.
10-12	American Association of Obstetricians and Gynecologists, Homestead, Hot Springs, Virginia
17-19	5th Annual Cancer Conference, American Cancer Society and National Cancer Institute, Philadelphia, Pa.
26-27	Congress on Occupational Health, AMA, Rice Hotel, Houston, Tex.

OCTOBER

5-9	American College of Surgeons, Conrad Hilton Hotel, Chicago, Ill.
5-9	American Association of Public Health Physicians, New York Hilton, New York, New York
8-10	American College of Physicians, Hotel Biltmore, Los Angeles, Calif.
10-14	American Society of Anesthesiologists, Bal Harbour, Florida
15-21	Association of American Medical Colleges, Denver Hilton Hotel, Denver, Colorado
17-20	College of American Pathologists, Americana Hotel, Bal Harbour, Fla.
18-21	American College of Gastroenterology, Roosevelt Hotel, New York, N.Y.
18-23	American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Ill.
23-24	American Heart Association, Chalfonte-Haddon Hall, Atlantic City, New Jersey
24	American Academy of Pediatrics, New York Hilton, New York, N.Y.
28-30	American Cancer Society, Biltmore Hotel, New York, New York

NOVEMBER

7-8	National Conference on Disaster Medical Care, LaSalle Hotel, Chicago
9-12	Interstate Postgraduate Medical Association of North America, Pittsburgh, Pennsylvania
16-19	Southern Medical Association, Memphis, Tennessee
20-21	American Psychiatric Association, Bellevue Stratford Hotel, Philadelphia, Pennsylvania
28-29	American College of Chest Physicians, Interim Meeting, Miami Beach, Florida
29	National Conference on Medical Aspects of Sports, AMA, Miami Beach, Fla.
29-Dec. 2	AMA Clinical Meeting, Miami Beach, Florida

ARTHRALGEN® helps fre





ARTHRALGEN®

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.

Arthralgen, a better-tolerated analgesic formulation of time-tested ingredients, works faster to free the arthritic from his pain without salicylate side effects. Since its analgesic components require no chemical conversion to act in the body, Arthralgen's pain relieving benefits are immediately available to provide a smoother, more rapid obtundation of pain than can be achieved with many true salicylates.

Arthralgen is especially useful for the prompt relief of early morning stiffness and pain with less risk of gastric irritation. And since Arthralgen contains no sodium it is safe for long-term use in arthritics who have other conditions which nec sitate sodium restriction.

ARTHRALGEN®-PR

Each tablet contains:

Salicylamide	250 r
Acetaminophen	250 r
Ascorbic acid (Vitamin C)	25 r
Prednisone	1 r

The basic Arthralgen formulation plus pred sone is indicated for patients who require stero Prednisone has three advantages over cortisc hydrocortisone, and ACTH. They are: (1) lacl sodium retention, (2) absence of increased po sium excretion, and (3) the unlikelihood of ster induced hypertension.*

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicate the management of rheumatoid arthritis, ac

arthritic joints from



I



N

outy arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms, dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

A. H. ROBINS CO., INC.
RICHMOND, VIRGINIA

KENTUCKY STATE MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1963-1964

Officers

GEORGE P. ARCHER, Prestonsburg ..... President
DELMAS M. CLARDY, Hopkinsville ..... President-Elect
DAVID M. COX, Louisville ..... Immediate Past President
CARLISLE MORSE, Louisville ..... Vice President (Central)
CARL C. COOPER, Bedford ..... Vice President (Eastern)
JOHN DICKINSON, Glasgow ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, Corbin ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
DOUGLAS E. SCOTT, Lexington ..... Chairman of the Board of Trustees
GABE A. PAYNE, JR., Hopkinsville ..... Vice Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

Trustees

First District ..... O. LEON HIGDON, 2515 Broadway, Paducah 1965
Second District ..... HOWELL J. DAVIS, 330½ Allen Street, Owensboro 1964
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville (serving interim term) 1964
Eighth District ..... DON JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1964
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1964
Eleventh District ..... HUBERT C. JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... CLYDE C. SPARKS, Mayo Arcade, Ashland 1964
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

Buyers Guide

JOURNAL OF THE KSMA BUYERS GUIDE FOR SEPTEMBER, 1964

Ames Company 737
Burroughs Wellcome 711-726
Coca-Cola Company 726
First Texas Pharmaceuticals 723
Geigy Pharmaceuticals 718
Glenbraak Laboratories 650
J. J. B. Hilliard 722
The Keeley Institute 729
KEMPAC 730
Wm. Kendrick Jewelers, Inc. 729
Kentucky Hotel 712-713
Lederle Laboratories 676-677-64S-721
Eli Lilly & Company 660
Madison State Hospital 716
Medical Protective Company 72S
William S. Merrell Company 708-709
Mt. Holly Nursing Home 72S
New Castle Sanitarium 729
Emerson A. North Hospital 719
Parke, Davis & Company 644
Pfizer Laboratories 6S1-6S3-6SS-6S6-6S7
A. H. Robins Company 6S9-734-73S
Roche Laboratories 738
G. D. Searle & Company 67S
Smith Kline & French 6S2
Southern Arms Apartments 731
Southern Optical Company 727
U. S. Vitamin & Pharmaceutical 717
Vanderbilt University 727
Wanted 732
Wallace Laboratories 649-6S8-706-714-71S-724
Winthrop Laboratories 647



"the same old story, doctor—indigestion"

The patient's complaint is indigestion...especially of intolerance to fried foods...aggravated by stress. You diagnose functional G.I. disturbance and associated stress...as manifested by flatulence, "nervous" indigestion and constipation. Prescribe

DECHOLIN-BB®

(Hydrocholeretic • Antispasmodic • Sedative, AMES)

Each Tablet Contains:

BUTABARBITAL SODIUM.....15 mg (¼ gr)
(Warning: May be habit forming) to ease nervous tension

DEHYDROCHOLIC ACID.....250 mg (3¾ gr)
to produce large volume of watery bile, hydrate the bowel contents and gently stimulate the intestinal mucosa

BELLADONNA EXTRACT.....10 mg (⅙ gr)
to reduce smooth-muscle hypertonus

Average adult dose: 1, or if needed, 2 tablets three times daily. *Precautions:* Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction. Caution drivers against possible drowsiness. *Side effects:* Dehydrocholic acid may cause transitory diarrhea; belladonna — blurred vision, dry mouth. *Contraindications:* Biliary tract obstruction, acute hepatitis, glaucoma, and prostatic hyperplasia. *Available through your regular supplier:* DECHOLIN-BB, bottles of 100 tablets. 72664

Ames Company, Inc., Elkhart, Indiana. AMES



for
The Age of
Anxiety

In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment.

Supplied—Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.

ROCHE

LIBRIUM®
(chlordiazepoxide HCl)

Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, N.J. 07110

OCTOBER 1964 • VOLUME 62 • NUMBER 10

THE JOURNAL

OF THE KENTUCKY STATE MEDICAL ASSOCIATION



LIBRARY
COLLEGE
OF PHYSICIANS
JUL 8 1965
LIBRARY
LEE RAMSDELL & CO., INC.

In This Issue

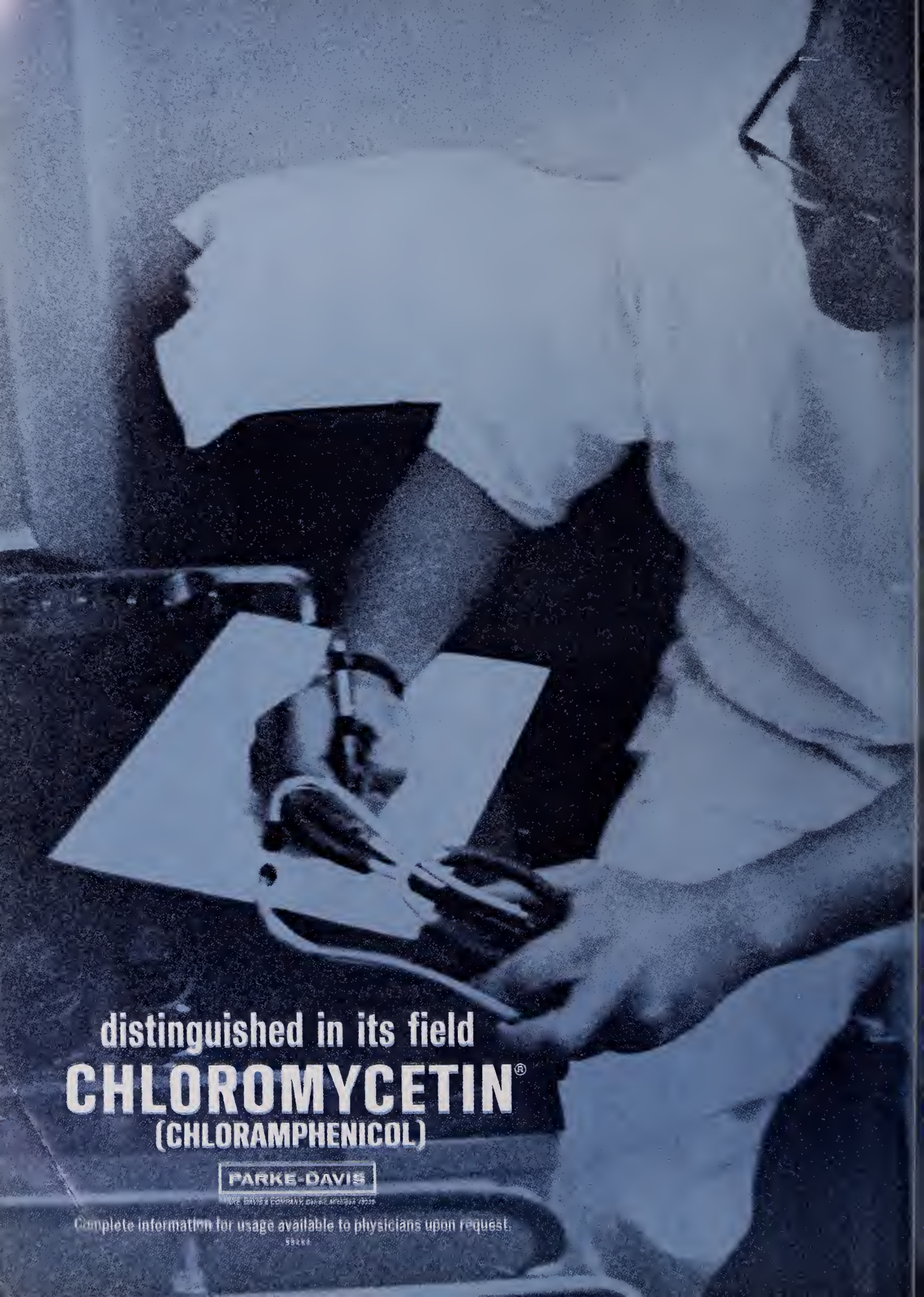
Some Present and Future Problems in the Treatment of Heart Disease
Tinsley R. Harrison, M.D. 753

Placentascan as a Diagnostic Aid
J. Patrick Sutherland, M.D. 761

Review and Evaluation of 800 Anesthetics Administered for Cesarean Section Delivery
Ryland Raesch, M.D., Sprague Gardiner, M.D., and V. K. Stoelting, M.D. 765

Role of a Non-Psychiatric Physician in a Mental Health Program
Harold J. Schupbach, M.D. 768

Complete Contents on Page 742


distinguished in its field
CHLOROMYCETIN®
(CHLORAMPHENICOL)
PARKE-DAVIS
PARKE, DAVIS & COMPANY, DETROIT, MICHIGAN 48232
Complete information for usage available to physicians upon request.
59464

Just Ready From Saunders!

DOCTOR'S EASACCOUNT RECORD SYSTEM

Saves time and effort in maintaining your financial records

The *Doctor's Easaccount Record System* is a brand new way to ease the burden of your financial record keeping. It enables you or your office assistant to maintain a see-at-a-glance report on income and expenditures, keep a central source of information for income-tax time, and hold the time and expense required for professional audit to a minimum—all with less time and effort. The system is contained in two convenient ledgers; one for disbursements (sufficient for two years' average practice), and one for income (sufficient for one year's average practice). Recording of expenditures is simplified by clearly labelled columns covering: *Salaries—Rent—Drugs and Medical Supplies—Instruments—Utilities—Stationery—Taxes and Insurance—Cost of Auto, Furniture and Equipment*—plus eleven other categories. Columns are provided for house expenses of the physician whose office is in his residence . . . an especially bothersome problem when computing deductible expenses. The Income Volume helps you keep a daily record of: *Date and Time—Patient—Professional Service—Charges—Receipts—Verification of Transfers to Patients' Cards—Bank Deposits*—plus daily, monthly, and yearly totals. These records are expressly set up for the specific requirements of a medical practice. All instructions necessary appear on a single page in the front of each volume.

Two volumes in a flexible cover. *Disbursements Volume*, 96 pages, 10″ x 12″; *Income Volume*, 256 pages, 10″ x 12″. Set—About $9.50.
New—Just Ready!

Hughes' PEDIATRIC PROCEDURES

Hundreds of hints, helps and shortcuts in methods of child care

Here are clear, step-by-step instructions to help you perform a wide range of technical procedures necessary in the management of children. Augmented by helpful illustrations, the procedures range from *inspection of the ear* to *venous cutdown*. In an uncomplicated, straightforward manner Dr. Hughes tells you: the best sites for venipuncture in infants; the equipment necessary for exchange transfusions; sizes of needles for bone marrow aspiration and biopsy; how to insert a nasogastric tube; hazards and complications of abdominal paracentesis; method of cardiac massage for infants, for small children; for older children; etc. The procedures explained include both routine and special measures: *taking the temperature—measurement of blood pressure—intravenous transfusion—subcutaneous injections—tuberculin skin tests—bone marrow aspiration—lumbar puncture—tracheostomy—percutaneous liver biopsy—enemas—bandaging—nonsuture skin closure—collection of sweat for the diagnosis of cystic fibrosis of the pancreas.* Valuable information is contained on restraining the infant or child—dental health—communicable diseases—methods of reducing pain of injections, etc. This manual will help you ease the stress, strain and trauma involved in performing these procedures on your young patients.

By WALTER T. HUGHES, M.D., Assistant Professor of Pediatrics, University of Louisville School of Medicine, Louisville, Kentucky. About 256 pages, 6⅝″ x 9¾″, with about 127 illustrations. About $8.00.
New—Just Ready!

Bates & Christie's RESPIRATORY FUNCTION IN DISEASE

Aid in problems ranging from ventilation measurement to respiratory failure

Drs. Bates and Christie brilliantly delineate today's useful knowledge about pulmonary physiology in this timely volume on the lung. The authors begin by reviewing and illuminating the methods available for studying lung function, and outlining the anatomy and values for the normal lung. They point out the advantages and disadvantages of current methods. They clearly describe changes in pulmonary function, as a consequence of age or obesity and in different body positions. What is known about pulmonary adaptation to altitude and to exercise is outlined. The major sections of the book describe individual disease entities of the lung—covering clinical features, radiologic features, and pathology. The authors provide exhaustive explanation of the pathophysiologic effects of each disorder on overall pulmonary function. Special stress is placed on pulmonary emphysema in all its forms, on chronic bronchitis and respiratory failure, on lung diseases caused by physical and chemical agents, and on the secondary effects of heart disease. Detailed case presentations of 54 patients augment the text.

By DAVID V. BATES, M.D., (Cantab.), M.R.C.P. (London), Associate Professor of Medicine, McGill University; Director, Respiratory Division, Joint Cardiorespiratory Service, Royal Victoria Hospital and Montreal Children's Hospital; and RONALD V. CHRISTIE, M.D. (Edinburgh), M.Sc. (McGill), B.Sc. (London), Sc.D. (Dublin), F.A.C.P., F.R.C.P. (London), F.R.C.P. (C), Professor and Chairman of the Department of Medicine, McGill University; Physician-in-Chief, Royal Victoria Hospital. With the assistance of MARGARET E. BECKLAKE, RICHARD E. DONEVAN, ROBERT G. FRASER, J. A. PETER PARE, W. M. THURLBECK. About 560 pages, 7″ x 10″, illustrated. About $15.00.
New—Just Ready!

W. B. SAUNDERS COMPANY West Washington Square, Phila., Pa. 19105

Please send and bill me:

☐ Doctor's *Easaccount Record System* About $9.50
☐ Hughes' *Pediatric Procedures*_____About $8.00
☐ Easy Pay Plan ($5 per month)
☐ Bates & Christie's *Respiratory Function*_____About $15.00

Name_____ Address_____ SJG 10-64

VOLUME 62 • OCTOBER 1964
Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Sam A. Overstreet, M.D.

• ASSOCIATE EDITOR
Wolter S. Coe, M.D.

• MANAGING EDITOR
J. P. Sonford

• ASST. MANAGING EDITOR
Ann M. Huntsmon

• DEPARTMENTAL EDITORS
Jock L. Chumley, M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscar J. Hayes, Case Discussions
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR
George F. Brockmon, M.D., Chairman
Willett H. Rush, M.D.
Blaine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Moore, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1967
Edward C. Graves, M.D.
Carl W. Kumpe, M.D.
Marvin A. Lucas, M.D.
Robert N. McLead, Jr., M.D.
Henry W. Post, M.D.
Clintan R. Patts, M.D.
Oscar Thompsan, M.D.
George I. Uhde, M.D.

Term Expires July 1, 1966
Harold L. Bushey, M.D.
Edward J. Fadell, M.D.
Merle W. Fawler, Jr.. M.D.
Joseph L. Galdstein, M.D.
John D. Lavett. M.D.
George F. McAuliffe, M.D.
Ralph G. Thomas, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965
McHenry S. Brewer, M.D.
Lewis Dickinsan, M.D.
Zygmunt Gierlach, M.D.
Douglas L. Gillim, M.D.
Arthur H. Keeney, M.D.
James B. Stith, M.D.
Chester B. Theiss, M.D.
Kearns R. Thompson, M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205
Subscription $8.00—single copy .80
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

Some Present and Future Problems in the Treatment of Heart Disease
Tinsley R. Harrison, M.D. 753

Placentascan as a Diagnostic Aid
J. Patrick Sutherland, M.D. 761

Review and Evaluation of 800 Consecutive Anesthetics Administered for Cesarean Section Delivery
Ryland Roesch, M.D., Sprague Gardiner, M.D., and V. K. Stoelting, M.D. 765

The Role of a Non-Psychiatric Physician in a Mental Health Program
Harold J. Schupbach, M.D. 768

CASE DISCUSSION

Tetanus
Donald M. Thomas, M.D. 771

SPECIAL ARTICLE

Physicians and Hospitals—Partners on the Health Team
Milford O. Rouse, M.D. 773

EDITORIALS

The Party Platforms 777
Dangerous Drugs 778
It's That Time Again 778

SPECIAL BLUE SHIELD SECTION 779

ORGANIZATION SECTION

Record Porticipotion Expected in Diabetes Detection Drive 787
AMA's 18th Clinicol Convention Begins November 28 in Miami 787
12th Ky. Rural Health Conference Theme is "Health Careers" 787
KSMA Health-O-Drama Exhibit at Fair Features Protection 788
Top Medical Lecturers Featured On Norton Seminar Dec. 17 788
SMA 58th Annual Meeting Set Nov. 16-19 in Memphis 790
Dr. Welch, 1964 AMA President, Dies During Wyoming Meeting ... 790
Communities Plan Observance of Oct. 18-24 Health Week 790
U. of L. Announces Medical Faculty Changes 790

REGULAR FEATURES

President's Page 744
Postgraduate 808
Insurance Page 810
In The Books 818
Maternal Mortality Page 820



NTz Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

NTz® Nasal Spray

NTz is more than a simple vasoconstrictor. It contains [N]eo-Synephrine® HCl 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; [T]henfadil® HCl 0.1% for topical antiallergic action; and [Z]ephiran® Cl 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium as chloride, refined), trademarks reg. U. S. Pat. Off. 17954B

Winthrop Winthrop Laboratories
New York 18, N. Y.

MESSAGE FROM THE PRESIDENT



The Struggle Continues

INFORMATION on current events appearing in the Journal must be prepared three or four weeks in advance of publication, therefore a message, or a part of the message, may be outdated by the time it reaches the reader. This fact renders the discussion of current day to day happenings a somewhat hazardous undertaking.

The Administration's efforts to get the House to pass the Senate version of the originally House-passed H. R. 11865 (amendments to Social Security of 1964 with the Gore-Anderson Amendment) were unsuccessful up to the time we go to press. A majority of experiencd observers appear to feel that the Senate version would continue to get unfriendly consideration in the House, as this is written.

We applaud the courage of our two Kentucky Senators in resisting the various pressures and voting against the Senate version of H. R. 11865 when it passed the Senate 49 to 44. According to the best information available, most of our Congressmen will not support the Senate version if it comes to a vote in the House. These Congressmen deserve our highest commendation.

Should we be successful in resisting the efforts to provide compulsory medical care for aged through Social Security this year, it will mean the war goes on even if we have won a highly important battle. It will amount to no more than a reprieve. The forces dedicated to socializing the medical profession will come back even harder next year.

There are many things we can do, and must do, if we truly want the free enterprise system of the practice of medicine to survive. It is time for reappraisal, realignment, re-uniting, re-dedication and renewed determination in our fight against socialization. Moderation is no longer sufficient to combat the extreme methods being used against us.

Delman M. Eldridge



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient").*

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

313-4



Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

Note:
Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae.*

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Cured with Signemycin
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017



*a result of 'METHEDRINE'® brand METHAMPHETAMINE HYDROCHLORIDE therapy

Her once unruly appetite is now well tamed with 'Methedrine' (methamphetamine hydrochloride)...an easy way to help control food craving and "hunger pains."

Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Complete literature available on request from Professional Services Dept. PML

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

'Methedrine' brand Methamphetamine Hydrochloride: Tablets–5 mg., scored, in bottles of 100 and 1000.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Of 1,021 children with various confirmed infections... 950 or 93.0% were treated successfully with Signemycin®

Note:
The effectiveness of Signemycin was demonstrated by Chattas and his co-workers* who administered Signemycin to 30 children with serious staphylococcal infections resistant to commonly used antibiotics. Only one failed to respond. In each case the use of this drug was indicated by antibiogram. Those children treated with a nonselected antibiotic—for comparative purposes—took three times longer to recover.

Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

Condition	No. of Patients	No. Cured with Signemycin
Eye, ear, nose, throat infections	368	343
Respiratory infections	369	346
Gastrointestinal infections	42	30
Skin and soft-tissue infections	38	37
Deep-seated or generalized infections	47	44
Various conditions	157	150
Totals	1,021	950 (93.0%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Signemycin is also available as half-strength Capsules, preconstituted raspberry-flavored Syrup and Pediatric Drops

Brief Summary and Bibliography follow.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017

Signemycin® Bibliography
1. Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957. 2. Arachi, N. and Gheradi, F.: Quad. Urol. 9:156, Apr.-June, 1959. 3. Arneil, G. C.: Antibiot. Ann. 1958-1959 327. 4. Arrigoni, G. et al.: Minerva Med. 48:2701, Aug. 25, 1957. 5. Baur, A.: Aerztl. Prax. 11:1845, Dec. 5, 1959. 6. Bellomio, S. et al.: Riv. Ital. Tracoma, vol. 10, Nos. 1-2, Jan.-June, 1958. 7. Bellomio, S. et al.: Riv. Ital. Tracoma, vol. 11, No. 1, Jan.-Mar., 1959. 8. Belonoschkin, B. and Lindgren, M.: Svensk. Lakartidn. 56:2134, July 31, 1959. 9. Bergdahl, U.: Svensk. Lakartidn. 55:1715, June 6, 1958. 10. Bhattacharyya, M. N. and Bhuyan, J. N.: Antiseptic 56:611, Aug., 1959. 11. Blass, R.: Schweiz. Med. Wschr. 89:158, Feb. 7, 1959. 12. Bolognesi, C.: Minerva Med. 48:2695, Aug. 25, 1957. 13. Candela, R. B.: Med. Esp. 46:273, Oct., 1961. 14. Cappelli, E.: Minerva Med. 48:2690, Aug. 25, 1957. 15. Carter, C. H. and Maley, M. C.: Antibiot. Ann. 1956-1957:51. 16. Caruselli, M. and Musca, A.: Minerva Med. 51:3516, Oct. 17, 1960. 17. Ceitlin, J.: Med. Panamer. 15:72, Aug. 1, 1960. 18. Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960. 19. Chiarenza, A.: Minerva Med. 48:2692, Aug. 25, 1957. 20. Cooper, J. et al.: Antibiot. Med. 5:302, May, 1958. 21. Cupples, J. F. B. and Perry, A. W.: Canad. Med. Ass. J. 77:699, Oct. 1, 1957. 22. David, N. A. and Carter, P. B.: Rocky Mountain Med. J. 58:27, Mar., 1961. 23. Davis, W. G.: Clin. Rev. 1:21, Apr., 1958. 24. de Lellis, J.: Dia Med., Apr. 24, 1958, p. 824. 25. Dienz, H.: Aerztl. Prax. 13:1797, 1961. 26. Dietel, V. and Meissner, F.: Deutsch. Gesundh. 16:2470, Dec. 28, 1961. 27. Dryjski, J.: Pol. Tyg. Lek. 24:1113, June 24, 1959. 28. Durrieu, C. A. et al.: Antibiot. Ann. 1958-1959:297. 29. Faz Tabio, H.: Rev. Cuba. Pediat. 30:219, Apr., 1958. 30. Febles Alonzo, D. and Batthyany, C.: Actas Ginecotocol. (Uruguay) 13:4, Aug., 1959. 31. Febles Alonzo, D. and Biderman, I.: Antibiot. Ann. 1958-1959:270. 32. Fiora, F. and Compa, F.: Dia Med., Apr 3, 1958, p. 570. 33. Garre, E.: Antibiot. Med. 7:285, May, 1960. 34. Geiger, K.: Praxis 15:365, Apr. 9, 1959. 35. Gemma, G. B. et al.: Minerva Med. 48:2643, Aug. 25, 1957. 36. Gerner, G.: Arzneimittelforschung 9:484, Aug., 1959. 37. Grazia, G.: Clin. Pediat. (Bologna) 41:1005, Nov., 1959. 38. Greco, O.: Med. Condotto-Med. Prat. 9:497, 1958. 39. Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958. 40. Henne, H. F.: Med. Klin., No. 29, July 18, 1958, p. 1267. 41. Heredia Diaz, J. et al.: Medicina (Mex.) 38:308, July 10, 1958. 42. Herrera, W. A.: Dia Med. 30:3116, Dec. 8, 1958. 43. Hoffmann, H.: Medizinische (Stuttgart) 45:1830, Nov. 8, 1958. 44. Kelleher, D.: Practitioner 182:227, Feb., 1959. 45. Kleine, W. and Hagen, H.: Ther. Gegenw. 98:171, Apr., 1959. 46. Klovstad, O.: T. Norsk. Laegeforen. 77:681, Aug. 15, 1957. 47. Kobari, K. and Tajiri, I.: Naika No Ryoiki (Field of Internal Medicine) 7:245, May, 1959. 48. Kohler, H. F.: Clin. Rev. 1:16, Apr., 1958. 49. Kraljevic, R. et al.: Antibiot. Med. 5:364, June, 1958. 50. La Caille, R. A. and Prigot, A.: Antibiot. Ann. 1956-1957:67. 51. Lapeyre, L. et al.: Marseille Med. 99:953, 1962. 52. Levi, W. M., Jr. and Kredel, F. E.: J. S. Carolina Med. Ass. 53:178, May, 1957. 53. Loughlin, E. H. et al.: Antibiot. Ann. 1958-1959:293. 54. Loughlin, E. H. et al.: Antibiot. Med. 7:739, Dec., 1960. 55. Mathur, S. N. and Joshi, V. S.: J. Indian Med. Ass. 34:437, June 1, 1960. 56. Moggian, G.: Minerva Med. 48:2648, Aug. 25, 1957. 57. Molinelli, E. A. et al.: Antibiot. Ann. 1957-1958:692. 58. Montilli, G. and Avellino, M.: Dermatologica (Basel) 9:2, 1958. 59. Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716. 60. Morador, J. L. and Saldana Tate, L.: An. Ateneo, Clin. Quirur. 1:52, Jan., 1958. 61. Morel, A. S.: Clin. Rev. 1:18, July, 1958. 62. Morey, G. S. et al.: Rev. Hosp. Nino (Lima) 18:293, 1957. 63. Ottolenghi, C. E. et al.: Bol. Soc. Cir. B. Air. 41:739, Nov. 6, 1957. 64. Pagola, J. G. et al.: Antibiot. Ann. 1958-1959:287. 65. Pavone, M. et al.: Minerva Urol. 70:121, Sept.-Oct., 1958. 66. Porrazzo, F.: Gazz. Med. Ital. 118:550, Dec., 1959. 67. Prats, F. and de la Parra, M. A.: Antibiot. Ann. 1959-1960:484. 68. Prokop, O.: Prakt. Arzt. 12:145, Feb. 15, 1958. 69. Ramirez Boettner, C. M. et al.: Rev. Med. Paraguay 5:269, July-Sept., 1960. 70. Randig, K.: Deutsch. Med. J. 8:447, Aug. 15, 1957. 71. Saavedra Amaro, S. and Lopez Zepeda, L.: Medicina (Mex.) 38:396, Aug. 25, 1958. 72. Saldana Sotomayor, F.: Medicina (Mex.) 39:191, May 10, 1959. 73. Santos, A.: Rev. Brasil. Med. 16:463, July, 1959. 74. Schenone, H.: Antibiot. Ann. 1958-1959:316. 75. Schunk, A.: Int. Rec. Med. 173:143, Mar., 1960. 76. Sgarzini, L. and Amato, R.: Ann. Stomat. 7:499, July, 1958. 77. Shubin, H.: Antibiot. Med. 4:174, Mar., 1957. 78. Sundberg, R. H.: Antibiot. Med. 7:115, Feb., 1960. 79. Talbot, J. R.: Wisconsin Med. J. 57:237, June, 1958. 80. Tato, J. M. et al.: Antibiot. Ann. 1957-1958:675. 81. Weithofer, W.: Medizinische (Stuttgart) No. 33-34:1490, Aug. 22, 1959. 82. Willcox, R. R. and Rosedale, N.: Brit. J. Vener. Dis. 38:19, Mar., 1962. 83. Willemot, J. P. et al.: Bruxelles Med. 38:1026, June 22, 1958. 84. Winton, S. S. and Chesrow, E. J.: Antibiot. Ann. 1956-1957:55. 85. Wolman, B.: Practitioner 185:199, Aug., 1960. 86. Yodh, B. B.: J. J. J. Group Hosp. 5:183, July, 1960. 87. Zaldivar, C. G. and Falcone, F. L.: Rev. Hosp. Nino (Lima) 20:141, June, 1958.

SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017



Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87]
In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017



and it's not a once-over-lightly one, either. All rubber stoppers used in Lilly ampoules are scrupulously cleaned with a detergent and hot deionized water in a special washing machine like the one pictured above. This removes any foreign matter adhering to them. Then the stoppers are autoclaved at 120° to 121°C. for one hour. They are now clean, sterile, and ready for use. In case the stoppers are not used within seventy-two hours, they are returned for resterilization. □ This meticulous process is only one of the many safeguards to insure the quality of the finished product and to protect the ultimate user.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

401196

The JOURNAL of the
Kentucky State Medical Association

Issued Monthly Under the Direction of the Board of Trustees

VOLUME 62 OCTOBER, 1964 No. 10

Some Present and Future Problems in the Treatment of Heart Disease

The T. Cook Smith Memorial Lecture † *

Tinsley R. Harrison, M.D.**
Birmingham, Ala.

Despite the inherent difficulties it is probable that surgical treatment will ultimately become as valuable for disorders of the myocardium as for those of the pericardium and endocardium.

OF THE many pleasant memories from my days as a medical student, none are more treasured than those of T. Cook Smith. He was one of my few friends with whom it was possible to converse without embarrassing and, at times, uncomfortable hyperextension of the cervical spine. Although his body was short, his mental stature was tall. His penetrating intellect was quick to detect errors on the part of his confreres but his charitable and tolerant nature made him equally ready to forgive them.

Cook Smith was possessed of a strikingly original as well as a highly critical mind. Had he wished a research career he probably would have achieved wide renown. But, like Cyrano de Bergerac, he preferred to say, "Non, merci" to fame. He wished to devote his time to people. His success in this endeavor, as your Professor of Pediatrics, is attested by your presence here tonight, which expresses the devotion of his friends, his students and his patients to the memory of this inspiring teacher and dedicated physician.

During the almost three decades which have passed since Cook Smith's untimely death, medicine has advanced rapidly in almost every area. My own ignorance of pediatrics prohibits a more appropriate discussion which would be centered on that specialty, and dictates the choice of a subject which has broad overtones in surgery and in internal medicine. In any case, his breadth of interest in all aspects of his profession and his deep attachment to patients —adults as well as children—simplify the choice of a topic.

We need not dwell in detail on the remarkable achievements in the cardiovascular field during the past quarter century. Among the more spectacular have been the widespread prevention of syphilitic aortitis, with its dreaded complications, and the decline in mortality of bacterial endocarditis from practically one hundred to about twenty-five per cent. The reduc-

†*Address to the Innominate Society, Louisville, Ky., March 10, 1964.*

**The work on which this lecture is based was aided by grants from the U. S. Public Health Service, #5 T2 HE 542-15, the Bishop Foundation, Mr. Hugh Kaul, the Elesabeth and Barbara Ingalls Foundation, and the Calhoun County Heart Association.*

***Professor of medicine, Medical College of Alabama, University of Alabama, Birmingham, Ala.*

tion in recurrences of rheumatic fever in children will presumably soon be reflected in a sharp decrease in the incidence of disabling valvular diseases in adults. As a pediatrician, Cook Smith would have derived especial satisfaction from the improved management of congenital heart disease. His realization that one of the prime movers and pioneers in this area was his fellow Georgian, classmate and intimate friend, Alfred Blalock, would have expanded this gratification.

One wonders whether the advances in the detection of renovascular hypertension, and in the control of blood pressure by drugs, would have preserved Cook Smith's life had this knowledge been available thirty years earlier. Such speculation is perhaps idle on the part of one who was his friend rather than his doctor. It is my impression that the long-standing glomerulonephritis contracted during adolesence would ultimately have proven fatal but that the vicious cycle of renal hypertension, leading to vascular injury, producing malignant hypertension, and causing fatal uremia, would have rotated at a slower rate, and that his patients and pupils would have had at least a few more years of their highly privileged association with this remarkable man.

Coronary Disease

When we turn from this cursory summary of recent progress to some pressing present problems in the field of cardiac disorders, our attention is necessarily first focused on the fearsome spectre of coronary disease. In the United States this has long since replaced tuberculosis as "Captain of the Men of Death." The many unsolved questions about treatment are not likely to yield easy or complete answers in the foreseeable future. But there is some handwriting on this wall, too.

The problems in the management of coronary disease are being attacked on a broad front. The value of diet and of various other procedures aimed at reduction of serum lipids in the prevention and treatment of ischemic heart disease are under intensive study. The long-held clinical impression that emotional stress is particularly harmful now seems to be supported by more direct evidence. We may turn our attention away from these questions and toward certain problems which have been of particular interest to our own research group.

The uncertainty concerning the baneful versus beneficent effects of physical exercise is not a new puzzle. Thus William Heberden, in his original description of angina pectoris, while emphasizing the predominance of exertion as a precipitant of the seizures, also said, "I knew one who set himself a task of sawing wood for half an hour every day and was nearly cured." The statistical evidence from Great Britain,[1,2] and from the United States[3] that mortality due to myocardial ischemia is decidedly less in those pursuing occupations requiring considerable physical activity than in those who live a more sedentary existence, seems to be overwhelming. Studies on dogs with experimental reduction of coronary flow suggest that regular exercise decreases the hazard of subsequent further reduction.[4] Records of absolute precordial movement (kinetocardiograms) indicate that in some patients (the exact per cent is unknown) with angina pectoris and abnormal tracings at rest, progressive exertion may first cause improvement[5,6] and then deterioration of contraction as the pain threshold is approached. In other patients the same effort may cause improvement in certain areas and impairment in others (Fig. 1). The available evidence, therefore, suggests that physical exertion not only tends to prevent ischemic heart disease, but, when adjusted to the needs of a particular patient, may also be of therapeutic value. One may add that the psychic benefits of a positive approach, i.e., advising patients to "Do" as well as to "Don't," are often great.

Of all controversial questions, those relating to the use of anticoagulants in patients with

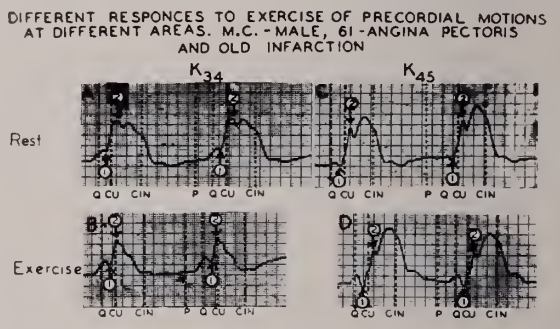


Fig. 1. Paper speed 50 mm. per second. All traces display two complete cardiac cycles, beginning and ending at the onset of the P wave. Q, CU, and CIN designate, respectively, the start of ventricular excitation, the beginning of the carotid upstroke, and the time of the carotid incisural notch. A and B: The record from the V_3 point (K_{34}) displays impravement, i. e., a slight decrease in the implitude and a marked decline in the duration of the abnormal outward systolic motion (arrow 1), as well as an increase in the downstroke during ejection (arrow 2). C and D: Following exercise, the abnarmal outward systolic motian is increased (arrow 1), and the inward movement during early ejection, which was markedly less than normal before the exercise, is reduced even further. The figure indicates improvement of precordial motions after exercise in one area and aggravation of the abnarmality after exercise in another.

TABLE 1

Certain Complications of Anticoagulant Therapy of Acute Myocardial Infarction

Patient	Age	Sex	Manifestations of Complication	Subsequent Course and Remarks
WFF	67	M	Acute abdominal pain, collapse: negative abdominal exploration	Acute then permanent adrenal insufficiency; hemorrhage into adrenals
RW	64	M	Severe pain in back, recurrence with radiation to abdomen one week later	Football-sized hematoma in left flank after 2nd episode Retroperitoneal hemorrhage
ERMc	53	M	Progressive dyspnea and painful enlarged liver. Huge heart shadow	Massive hemopericardium 4900 ml. Bloody fluid. (Hematocrit 18-12 per cent.) Removed in three paracenteses during 2 weeks

EFFECT OF LONG-ACTING CORONARY DILATOR DRUG ON PRECORDIAL MOVEMENTS OF PATIENT (W.F., MALE, AGE 75) WITH CONGESTIVE FAILURE AND MYOCARDIAL INFARCTION

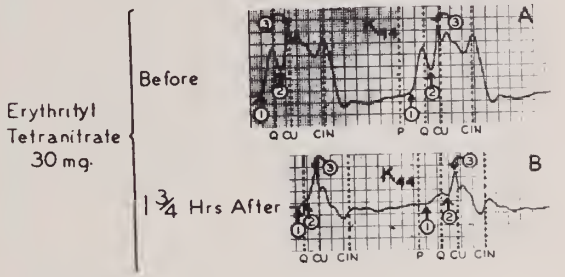


Fig. 2. The patient had sustained a severe myocardial infarction four years previously, and at the time of the study was having only rare anginal attacks of minimal severity. However, congestive failure was pronounced. A: Before the administration of erythrityl tetranitrate the movements reflecting atrial activity (arrow 1) were abnormally large, and during ventricular systole there was a large sustained outward motion (arrow 2), with only a small inward motion during ejection (arrow 3). B: Following the administration of erythrityl tetranitrate in a dose twice that commonly utilized, the atrial motions diminished markedly to a normal amplitude, the size of the abnormal outward motion during isometric contraction decreased somewhat (arrow 2), and the inward motion during ejection (arrow 3) increased markedly. The record suggests improvement in the mechanical function of the heart in a patient with congestive failure due to ischemic heart disease, but independently of episodes of ischemia pain.

ischemic heart disease merit first rank. The sequence here is similar to that for most new remedies. Having passed through the original "Gee-whiz" state of overenthusiasm, we now seem to be in the secondary "Aw, nuts" phase of excessive scepticism. In time we shall probably arrive at the more judicious "Yes, but—" view, with a clearer understanding of the value, limitations and hazards of these drugs.

Some relatively rare complications of anticoagulant treatment are illustrated in Table I. Although each of these patients recovered from the life-threatening internal bleeding, these and similar experiences have led us to prefer errors on the side of conservatism in dosage. Pending more complete information and in the absence of overt contraindications, we still utilize anticoagulants for some weeks in patients with acute myocardial infarction, and for a longer period in subjects with frequent and severe episodes of ischemic pain (preinfarctional angina) at rest.

We are slow to embark on long-range anticoagulation, although the available evidence[7] would seem to favor such treatment during the initial six to twelve months after myocardial infarction. Indeed, there is a report[8] of striking reduction in the mortality rate of patients with angina pectoris but only provided intensive management was instituted at an early stage of the disease. There is reason to believe that heparin is superior to the oral drugs for long-range treatment.[9]

The studies of Langley[10] have clarified the disputed question of the value of the long-acting coronary dilator drugs. He has found that these preparations, which are sometimes ineffective in the usual dosage, nearly always produce benefit (objective as well as subjective) when employed in amounts just less than those required to cause demonstrable pharmacologic effects in the form of headache or hypertension. We shall not discuss here the untoward actions of these drugs, which are minimal in most people. Some patients require from three to five times the commonly employed dose as often as every three hours.

The observations of Langley also suggest that the long-acting dilators may sometimes have value in persons with ischemic heart disease, who are suffering from congestive failure rather than angina. Thus the patient illustrated in Fig. 2 demonstrated modest shortening of circulation time as well as striking improvement in precordial movements at the height of action of the drug. However, the frequency of such benefit remains unknown.

Problems in Cardiac Surgery

One of the major present problems in the cardiac field is that of the cause of death occurring shortly after operations on the heart. Although the mortality is surprisingly low after some procedures, it remains distressingly high after others and, especially, in older persons. Being human, the pediatrician or internist who

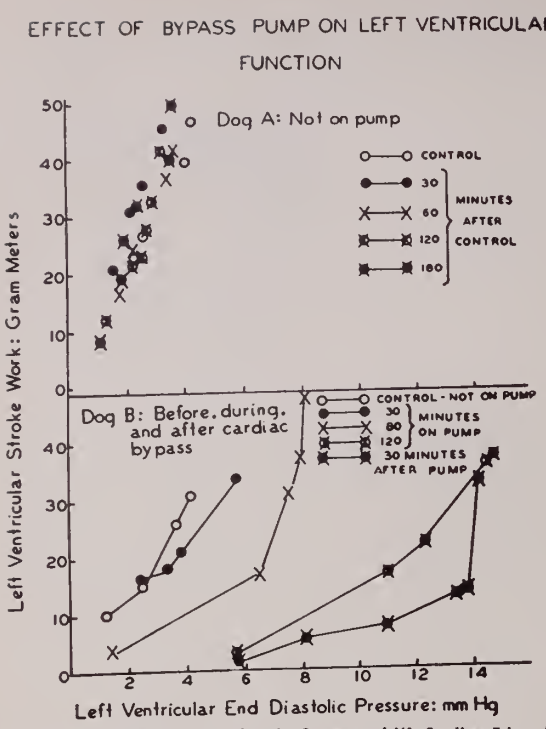


Fig. 3 (Courtesy of Drs. Gus G. Casten and W. Sterling Edwards, III) A: The left ventricular function of Dog A was not impaired by a period of three hours, with the chest open and the heart exposed. The ventricular function remained essentially constant during this period. B: During a period of cardiac bypass, the left ventricular function curves exhibited progressive impairment. During the 30 min. after bypass was discontinued, this impairment did not improve but progressed further. This experiment is typical of the findings in a series of similar observations.

advised the procedure is likely to assume that the surgeon's technique, rather than his own judgment was at fault. The surgeon, being also (and, perhaps, especially) human, will frequently hold the opposite view. Sometimes both will blame the anesthesiologist or, in the case of open-heart procedures, the operator of the pump. These attempts at self-justification may represent the end of the problem as well as of the patient.

It is improbable that anyone knows the past and current incidence of death and of long-term benefit from the recently developed cardiac surgical procedures. Those who encounter high mortality or find discouragingly little improvement in the survivors are likely to remain discreetly silent, while their more fortunate brethren take pen in hand. Such a statement implies no criticism of the individuals concerned who need not apologize for being human. It implies only that when we consider all the operations performed, the *actual* results are probably quite different from the *reported* results.

The large volume of work already done on experimental animals is a small fraction of what is needed in this area.

Since myocardial depression is probably the single commonest cause of death after an open-heart operation, the investigation of the effects of this procedure on cardiac function is an obvious point of departure. I am indebted to my colleagues, Drs. Gus Casten and Sterling Edwards, Jr., for Fig. 3, which illustrates their typical findings.[11] It may be noted that during a period of three hours left ventricular function remained essentially unchanged in a dog with an open chest and intact circulation. However, another healthy dog exhibited marked impairment following the shorter period of two hours of cardiac bypass. If such physiologic change occurs in a healthy heart subject to no direct trauma, how much greater impairment will be expected in an already overloaded organ after operative manipulation?

These remarks should not be misinterpreted. I have no wish to be a raven, croaking, "Nevermore!," as regards cardiac operations. As Oliver Wendell Holmes (senior) said, "I am only appealing to that higher court of experience which sits in judgment on all decisions of the lower medical tribunals, and which requires more than one generation for its final verdict." As will be apparent from what follows, it seems probable to me that the cardiac surgery of the future will have a much broader range of value than at present. This prediction is based on the assumption that within the next few years an increasing attention will be devoted to a study of the physiologic, biochemical, biophysical and morphologic deviations resulting from our present methods of cardiac bypass.

The application of surgical measures to the treatment of cardiac disorders has moved from the pericardium to the endocardium. Is there a reason to hope and believe that the major breakthrough of the future will involve the myocardium? Certain aspects of this problem may now be considered.

Cardiac Work

The chemical energy expended by the myocardial fibers is converted into several types of mechanical work. That which causes *change in position* by moving the entire muscle mass is wasted but is probably a small fraction both in normal and abnormal hearts. Thus the chief positional change is the recoil as ejection begins, which is responsible for the normal apex tap.

The magnitude of the work done in causing

TABLE 2

Types of Cardiac Work

I. Essential
- A: Isovolumic or "internal work," i.e., that causing:
  1. Gross shape changes as early contracting areas shorten and lead to passive stretch of late contracting areas
  2. Internal shape changes as shortening of contractile elements produce stretch of noncontractile components
- B: Ejection, i.e., external or useful work. This is roughly expressed by stroke volume x pressure. (The normally small "velocity factor" is neglected)

II. Wasted
- A: All work expended in causing positional change: (This work is probably a small fraction in all hearts)
- B. Excessive shape change during isovolumic contraction) These are small in normal hearts but may be very large in diseased hearts
- C: All shape change during ejection)

change in shape is greater. During isovolumic contraction the work performed in elevating tension and pressure is mainly expended in causing gross or microscopic changes in shape (Table II). Even in the normal heart this is a significant fraction of the total work. Because the different parts of the same ventricle begin to contract at different times, a portion of the work done by the early contracting fibers is spent in causing passive stretch of the late contracting areas. But the major shape change is presumably the minimal deformation of noncontractile elastic components caused by shortening of muscle fibers and resulting in a rapid rise in pressure. This type of shape work, while partly wasted in the strict mechanical sense, is essential physiologically.

During ejection, the work of the normal heart is mainly devoted to causing *change in volume against pressure.* This is useful work, whether viewed mechanically or physiologically. We may, therefore, construct certain crude expressions in which the energy lost as heat and the small amount of work causing change in position are neglected:

(1) Essential Work = Necessary Isovolumic Shape Work (i.e., "internal work") Ejection Work (i.e., "external work")

(2) Wasted Work = [Unnecessary Isovolumic Shape Work] + [All Shape Work During Ejection]

(3) Physiologic Effectiveness $\propto$ $\frac{\text{Essential Work}}{\text{Wasted Work}}$

(4) Mechanical Efficiency = $\frac{\text{Useful (Ejection) Work}}{\text{Energy Expended}}$ & $\frac{\text{Useful Work}}{\text{Total Work}}$

(5) Mechanical Efficiency $\propto$ $\frac{\text{Useful Work}}{\text{Shape Work}}$

There is evidence, from the studies on animals, that the mechanical efficiency of the normal heart is in the general range of 15 to 25 per cent, which is high as compared to most machines. The kinetocardiogram, which normally shows mainly the inward motion of volume change during ejection (Fig. 4), furnishes indirect evidence for a high degree of physiologic effectiveness of the normal human heart.

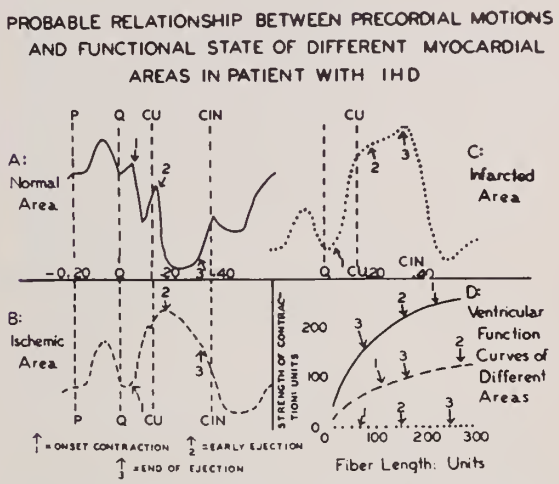


Fig. 4. Values on the abscissae indicate time in seconds, the onset of ventricular excitation (Q) being taken as zero time. P, CU, and CIN indicate, respectively, the onset of atrial contraction and the start of the carotid upstroke, and the carotid incisural notch.

A: The record from the normal area is similar to that obtained in precordial traces of normal subjects. During isometric contraction the main motion is inward (arrow 1). This is followed by a short upstroke due to recoil as ejection begins, and then a large inward motion due to volume change.

B: The ischemic area exhibits outward motion during isometric contraction, as the rising pressure causes a bulge of the weakly contracting region. However, during ejection the main motion is inward.

C: The infarcted area begins to move outward early in isometric contraction, and this outward motion continues through ejectin. The inward motion (arrow 3) starts only as relaxation begins.

D: The hypothetical function curves of the three areas are depicted. That of the normal area (upper curve) displays the expected decrease in the strength of contraction as the fiber length diminishes, due to ejection. The infarcted area has a flat line with no strength of contraction, and is passively stretched progressively during systole as the pressure rises. The curve of the ischemic area is intermediate. During isometric contraction the fibers are stretched (arrow 1 to arrow 2), but because of this stretch, shortening occurs during late systole (arrow 2 to arrow 3).

In the patient with ischemic myocardial disease the situation is different. The pronounced change in shape due to systolic ballooning of the ischemic area, which was first demonstrated in dogs by Tennant and Wiggers,[12] also occurs in may patients during anginal attacks,[5,13] and after infarction[14,15] (Fig. 4 B, C). Shape changes are exaggerated during isovolumic contractions, and in certain precordial areas the normal inward motion during ejection may be absent or superseded by additional paradoxical outward motion. The term *ventricular asynergy,* which has been applied to this phenomenon,[16] may be defined as *a state of inefficiency* characterized by an *excessive diversion of the ventricular work into shape* (and/or positional) *change as compared to volume* (flow X pres-

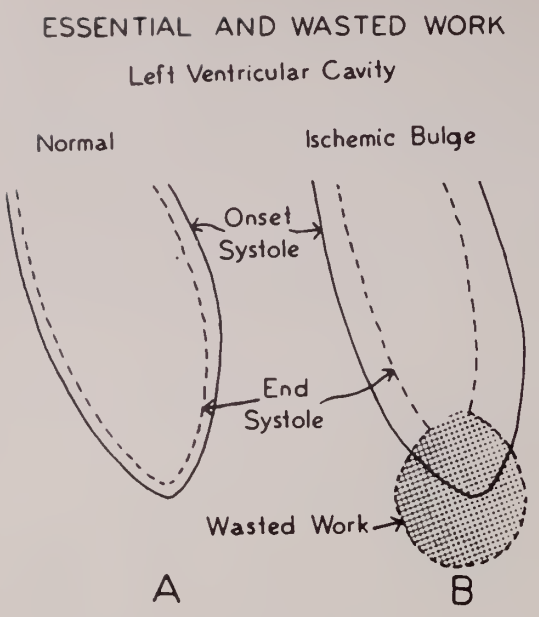


Fig. 5. A: In the case of the normal. ventricle, the decrease in size of the cavity is entirely due to the expulsion of blood to the aorta. B: The systolic diminution in size of the cavity of the ventricle with the ischemic bulge involves two factors: Blood is displaced not only into the aorta but into the bulging area. Since the pressure is the same during ejection in the root of the aorta and in the left ventricular cavity, the ratio of volume of blood expelled into the aorta, divided by volume of blood expelled into the bulge, will indicate the proportion of useful external work as compared to wasted or internal work. This diagram is an obvious oversimplification but represents the principle concerned.

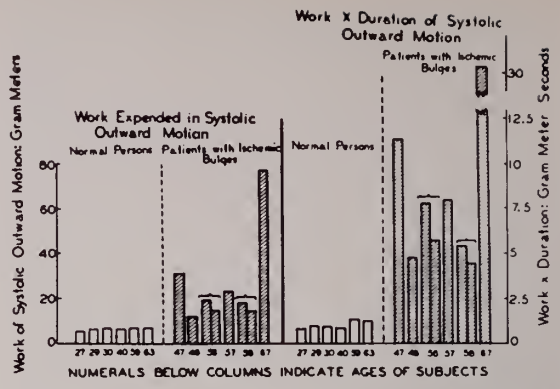


Fig. 6. (Courtesy of Dr. John O. Langley) An attempt is made to measure the work wasted in abnormal outward systolic motion by measuring the distance a known mass placed on the precrdium is lifted during systole. When only the mass X distance of the outward motion is considered, the patients with ischemic bulges displayed 2 to 10 times as much wasted work as did the normal persons. When the duration of the outward systolic motion is considered lrt. columns) the difference between the normals and the patients with ischemic bulges is even more pronounced. Although the factor of duration does not enter into the actual work, in the strict physical sense, the amount of effort involved and energy required to sustain the lift of a given weight is obviously greater than that involved in a brief and unsustained lift.

sure) *change*. The concept implies poor teamwork between the different portions of the same chamber.

The extreme form of ventricular asynergy is ventricular fibrillation, in which the function (Starling) curve of the entire chamber is flat. In the patient with ischemic disease the different parts of the same ventricle have different function curves, varying from the normal shape for the healthy fibers to the flat line of the infarcted region and the intermediate trace of the impaired but still viable areas (Fig. 4 D). Some of the work done by the sound fibers is wasted in causing systolic stretch of the diseased regions (Fig. 5). The crucial question is: How much?

The observations on dogs of Tennant and Wiggers,[12] of Murray,[17] and of Tyson et al[18] were in agreement in indicating significant functional impairment as the result of the systolic ballooning of noncontracting areas. Resection of such areas or prevention of their systolic expansion tended to restore the functional state.

Quantitatively valid studies of this phenomenon in man are lacking. *Measurements of pressure and flow can tell us only about the useful work of the heart and not about the wasted fraction*. They, therefore, furnish no reliable guide to physiologic effectiveness, as defined above. This problem is currently being attacked indirectly by Langley,[19] in our laboratory. He is attempting to determine the wasted work associated with ischemic paradoxical outward systolic motions by measuring the displacement of a known weight placed on the precordium. Despite the crudeness of the method and the technical difficulties, his data point toward a significant diversion of energy to wasteful shape work (Fig. 6).

The Future of Cardiac Surgery

This line of thought brings us back to a consideration of the future of cardiac surgery. Would patients with heart disease, like the dogs of Murray[17] and of Tyson et al,[18] be improved if not only anatomic ventricular aneurysms were resected, as was apparently first done in man by Bailey,[20] but if physiologic aneurysms which undergo wasteful systolic ballooning were also either removed or immobilized by some artificial means? Although a firm answer to this question cannot be offered at present, we may undertake an awkward first step by listing some of the various conditions which are associated with abnormal shape change during systole.

Ischemia (i.e., infarction and anginal attacks), which has been discussed in some detail, is only one of several conditions characterized by paradoxical systolic bulges. Among the others[15,16] are hypertrophy, left bundle branch block, ventricular premature beats, and extreme tachycardia. It is highly improbable that we shall

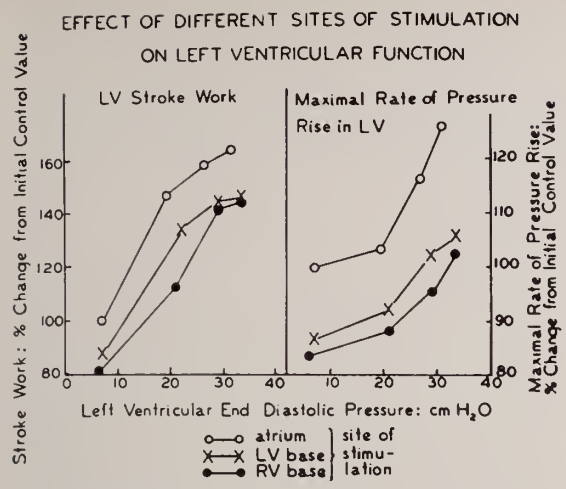


Fig. 7. (Courtesy of Dr. James O. Finney, Jr.) The data obtained from the dog herein illustrated are typical of those found in numerous observations on other dogs. Left ventricular function, whether judged by stroke work relative to end diastolic pressure (left column) or by the maximal rate of pressure rise relative to end diastolic pressure (curves on the right) was greatest when the atrium was stimulated, and the spread of ventricular excitation and contraction followed the normal sequence. Stimulation of the left ventricle caused moderate reduction in left ventricular function. This reduction was even greater when the site of stimulation was the right ventricle.

ever resort to surgical treatment for all of these conditions but not beyond reason to believe that one, or, perhaps, two of them, will ultimately be amenable to such an attack.

The evil effects of left bundle branch block are well known. That these are, in most instances, mainly due to the impairment of contractile function by the causative myocardial disease is unquestioned. But this cannot account for the evidence of diminished physiologic effectiveness occurring within a single beat in some patients with intermittent left bundle branch block.[16] Such an observation tells us that either the sequence or the duration of excitation or (more probably) both are important *per se*. This is another way of saying that *asynchrony* of contraction is one possible cause of *asynergy*. We do not know why the precordial movements are grossly abnormal in some asymptomatic patients with left bundle branch block and essentially normal in others.[15] Possibly, the exact paths of the abnormal spread of contraction is important. This is suggested by the observations of J. O. Finney, Jr.,[21] on the effects of excitation from different areas on the left ventricular function of the dog (Fig. 7).

These considerations may have certain implications in the surgical treatment of arrhythmias. *A priori* reasoning suggests that the insertion of a small series of small electrodes connected to an appropriate stimulator, into different subendocardial areas, should make it possible to reproduce the normal sequence of excitation. Such a procedure might be helpful in some patients with left bundle branch block and the present favorable results from artificial pacing in persons with atrioventricular block might be further improved.

The surgical attack on ischemic heart disease has thus far consisted mainly in pioneer efforts at: (1) inducing collateral arterial circulation, (2) direct widening of coronary channels by endarterectomy, and (3) resection of *anatomic* ventricular aneurysms. For reasons which have been mentioned, it seems possible that surgical treatment may soon be used for those *physiologic* aneurysms which balloon only during systole and, perhaps, also for those which readily appear during minor stresses. Possibly, the doors will be further opened for operative management of some subjects with conduction defects and some with cardiac hypertrophy.

Any broad attempt in the immediate future at such a radical approach is, perhaps, doomed to fail because of prohibitive mortality in these elderly patients. The usual person with symptomatic coronary disease suffers not only from focal areas of cardiac ischemia; the *"healthy" myocardial regions have been afflicted by birthdays*. The operative hazard of open-heart surgery, which is sometimes disturbingly high in young adults, might be truly appalling in these older persons. But this is probably a temporary situation that depends on lack of knowledge, and that can be remedied by more information.

In Summary:

The problems of coronary disease are, and will probably continue to be, at least equal in medical, social and economic importance to those of all other cardiac disorders combined. A growing body of evidence suggests that ischemia impairs myocardial function not only because of feeble contraction of damaged regions but also because of a state of poor teamwork, which reduces the effectiveness of the remaining healthy fibers. There is some reason to hope and even to believe that certain facets of this problem, such as ischemic ballooning, abnormal conduction and even hypertrophy, may become amenable to surgical treatment in the reasonably near future. Advance in the application of such surgical measures to these older patients will probably be achieved sooner if a major effort is first devoted to animal experiments aimed at improving our

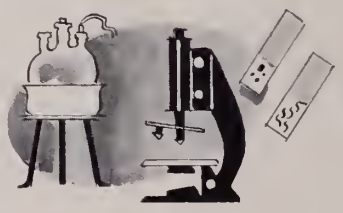
currently used procedures and our existing techniques.

Forty-six years have passed since T. Cook Smith entered medical school. It is, perhaps, no exaggeration to say that, during this short period, more progress has been made in the treatment of disease than in all previous time. Although much of this gain occurred during his life, the major advances in cardiac disease have appeared since his death. We regret that he did not survive to see them because no one would have appreciated them more.

I recall reading, while still a medical student, Osler's statement about the importance in a physician of the three H's: humor, humanity, and humility. At that time the thought occurred that no one known to me combined these virtues in greater degree than did T. Cook Smith. Subsequent associations during almost half a century have not altered that opinion.

References

1. Morris, J. N.: Epidemiological aspects of ischemic heart disease, Yale J. Biol. & Med., 34:366, 1961-62.
2. Morris, J. N.: Epidemiology and cardiovascular disease of middle age, Mod. Concepts C. V. Dis., Parts 1 & 2, 29:625, 1960; 30:633, 1961.
3. Taylor, Henry L.: Coronary heart disease in physically active and sedentary populations, J. Sports Med., 2:73, 1962.
4. Eckstein, R. W.: Effect of exercise and coronary narrowing on coronary collateral circulation, Circulation Res., 5:230, 1957.
5. Harrison, T. R., and M. L. Hughes: Precordial systolic bulges during anginal attacks, Tr. Assoc. Am. Physicians, 71:174, 1958.
6. Harrison, T. R.: Some clinical aspects of angina pectoris, The Bull. Johns Hop. Hosp., 104:275, 1959.
7. British Med. Res. Council. Report of working party on anticoagulant therapy in coronary thrombosis, Brit. M. J., 1:803 & 2:239, 1959.
8. Owren, P. A.: The results of anticoagulant therapy in Norway, A.M.A. Arch. Int. Med., 111:240, 1963.
9. Hughes, M. L., F. Mortensen, and L. Shourie: Comparison of continuous long-term heparin and oral anticoagulant therapy in patients with severe angina pectoris, 65:615, 1963.
10. Langley, John O.: Personal communication.
11. Casten, Gus G., and W. Sterling Edwards, III: Personal communication.
12. Tennant, R., and C. J. Wiggers: Effect of coronary occlusion on myocardial contraction, Am. J. Physiol., 112:351, 1935.
13. Hefner, L. L., B. Friedman, T. J. Rieves E. E. Eddleman, Jr., and T. R. Harrison: Symposium on coronary dilator drugs, Circulation 15:111, 1957
14. Suh, Soon Kyu, and E. E. Eddleman, Jr.: Kinetocardiographic findings of myocardial infarction, Circulation, 19:531, 1959.
15. Davie, J. C., J. O. Langley and E. E. Eddleman, Jr.: Clinical and kinetocardiographic studies of paradoxical precordial motion, Am. Heart J., 63:775, 1962.
16. Harrison, T. R.: Some unanswered questions concerning enlargement and failure of the heart, Am. Heart J., in press.
17. Murray, Gordon: Pathophysiology of cause of death from coronary thrombosis, Ann. Surg., 125:523, 1947.
18. Tyson, K., I. Mandelbaum and H. B. Schumacher, Jr.: Experimental production and study of left ventricular aneurysms, J. Thoracic & C. V. Surg., 44:731, 1962.
19. Langley, John O.: Personal communication.
20. Bailey, C. P.: Experimental and clinical resections for ventricular aneurysm, Surg., Gynec. & Obst., 104:539, 1957.
21. Finney, J. O., Jr.: Personal communication.



Our Advertisers

Are Our Best Friends

They Deserve Your Consideration

Placentascan* As A Diagnostic Aid Report Of 14 Cases

J. Patrick Sutherland, M.D.**
Louisville, Ky.

An attempt is made to acquaint the practitioner with a safe, relatively simple, and accurate method of determing the site of placental implantation, thus aiding him in the differential diagnosis of third trimester bleeding.

THE never ending quest of a means to improve methods and the quality of care available to the patient sometimes moves at what seems to be an extremely slow pace. The standard of medicine practiced in the United States illustrates that any new technique, whether diagnostic or therapeutic, capable of lowering the morbidity or mortality rate will be welcomed into the armamentarium. As a result of the work done by Browne and Veall[1], Weneberg[2], Hutchinson, Bennet and Gean[3], and Cavanaugh, Powe and Gilson[4], such a technique may now be emerging in the field of obstetrics. An advance such as Placentascan will not rival the work of Semmelweis for its profound effect on the morbidity and mortality rate, but it may well be "an inch on the yardstick of progress".

It is not the purpose of this paper to present any new technique, previously undescribed, but to reacquaint you with an accepted aid for the location of the placenta in the differential diagnosis of third trimester bleeding. The technique, emphasizing its simplicity, will be presented, as well as the results of its use in fourteen cases. In addition, two cases will be presented in detail.

PLACENTASCAN—A term coined by Cavanaugh et al. in the description of their technique in OBSTETRICS AND GYNECOLOGY, Oct. 1961 in preference to Isotopic Placentogram, which they considered to be a rather unwieldy term.

**Formerly a resident in Department of Obstetrics and Gynecology, St. Joseph Infirmary, Louisville. Doctor Sutherland is now in the U. S. Air Force.

TECHNIQUE

The technique used in these cases is basically the same as that described by Cavanaugh, Powe and Gilson[4]. The theory upon which Placentascan is based is the slow diffusion from the vascular compartment of the relatively large albumin molecule tagged with radioactive iodine. The distribution is physiological, and it is therefore reasonable to assume that one of the highest concentrations found in the vascular compartment will be at the site of placental implantation. In all instances, a scintillation counter, with automatic timer was used, employing a counting head having a two centimeter opening. The counting head is placed flush against the skin in the area to be scanned.

Prior to the Placentascan, the patient is administered ten drops of Lugol's solution in water. If delivery is not carried out within a matter of several hours, the same dose of Lugol's solution is repeated three times a day for three days. This is done to block any possible uptake of the I^{131} by the thyroid of the fetus. However, previous studies of cord blood and the thyroid of the infant failed to reveal any evidence of radioactive iodine uptake, even when Lugol's solution had not been administered.

With the patient in the supine position, the skin overlying the uterus is marked off into nine equal areas. Five microcuries of I^{131} tagged human serum albumin is then injected into an arm vein. After allowing ten minutes for equilibration, a one minute count is taken over the xiphisternum and the nine outlined skin areas. The count over each of these areas is then repeated, and the average of these two readings is used as the area value. The area value in each case is expressed as a per cent of the heart-pool reading obtained over the xiphisternum. These values are then inserted into the appropriate areas on a mimeographed form which contains the patient's name, age, gravida, para, estimated date of confinement and a brief clinical history. The average of the highest and lowest

area value is then computed. Any value above this average is considered significant. The approximate placental location is sketched on the previously mentioned form utilizing the areas whose values are significant. If relatively equal values are obtained for all uterine areas, posterior wall implantation may be suspected.

One copy of the Placentascan is placed on the patient's chart and a duplicate is kept in the Radioisotope Department. The attending physician is requested to note the location of the placenta at the time of delivery, and to record it on the Placentascan form. If delivery is carried out vaginally, it is essential that manual exploration of the uterus be carried out as soon as the trunk of the infant is delivered, in order to determine the site of implantation.

Advantages and Disadvantages

There are several advantages of Placentascan over other procedures for the localization of the placenta. Foremost are those which concern the well-being of the mother and infant.

Probably the most important is the fact that vaginal examination, with all of its potential hazards, is not essential to establish the correct diagnosis. This fact will be emphasized later by one of the cases presented.

Secondly, the amount of irradiation received by both the mother and infant is much less than that resulting from X-ray studies. It has been reported that, allowing for total decay of the I^{131}, as well as for the Beta and Gamma irradiation, the maximum fetal irradiation is approximately seventy milliroentgens. This represents approximately one-tenth the irradiation exposure from a single X-ray of the abdomen. As regards the maternal irradiation exposure, five microcuries of I^{131} is only one-eighth the average dose utilized in diagnostic thyroid uptake studies.

The accuracy of this technique is another strong advantage. In all of the studies that were reviewed, the accuracy was reported as well above ninety percent. In contrast, the reported accuracy of other methods of placentography ranges from 75 to 95 percent, depending upon the technique employed.

When compared with placentography on other points, it is found that Placentascan does not require the time or experienced personnel necessary for accurate placentography. With regard to expense to the patient, they are comparable when the technique of placentography requires more than one X-ray view.

The main disadvantage of Placentascan is its unreliability when carried out prior to the thirty-fourth week of gestation. However, with the advances being made in the equipment used, the reliability of the procedure may be expected to improve accordingly. Also, it is felt by most investigators that even at this time the results obtained by Placentascan are more reliable than those furnished by any other technique.

Results

Thus far in our study, a total of fourteen Placentascans have been done, ten of which were on patients who had experienced vaginal bleeding, without a resulting complication. The site of implantation was not satisfactorily determined at the time of vaginal delivery in two cases. Therefore, we do not feel justified in including these in the following statistics. However, it was obvious at the time of delivery that placenta praevia was not the etiology of the bleeding in either case.

The placenta was correctly localized in eleven, or 91.7%,* of the remaining twelve cases. Confirmation of the placental site was made at the time of cesarean section in seven of these cases.

One case in which the placenta was not localized was in fact unusual, in that it could not be localized at all by the Placentascan. The details of this case are as follows:

Mrs. T. W. S., a twenty-five year old gravida V, para III, abortion I, Rh negative white was admitted to the hospital on Oct. 16, 1962 because of the history of vaginal bleeding and uterine contractions. The estimated date of confinement according to menses was Nov. 17, 1962. According to the patient, she had not felt the infant move for approximately five weeks. She was not hemorrhaging at the time of admission. Examination of the abdomen revealed the uterus to be enlarged to approximately eight months size. The presenting part was not engaged, and no fetal heart beat or placental souffle could be detected. When the appropriate laboratory work had been carried out and blood was available, the patient was transferred to the Radioisotope Department where a Placentascan was done.

It was the opinion of the operator that the

Editor's Note: While there is a disagreement as to the possibility of an inaccuracy in the percentage, it is the feeling of the editor that this does not effect the overall value of the paper.

Isotope Laboratory St. Joseph Infirmary

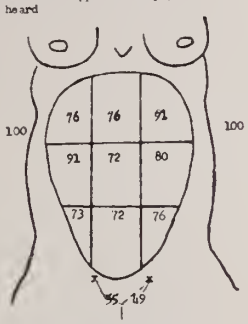
PLACENTASCAN

Patient Mrs. T.W.S. Rm. D.R. Age 25 Gravida V Para III EDC 17 Nov. 62

Physician _____ Log No. 408 Isotope No. 2865-1dI IHSA 5mc Date 10/16/62

History: This patient is a 25-year-old, gravida V, Para III white female, whose EDC was calculated as Nov. 17, 1962. Onset of uterine contractions and vaginal bleeding on the morning of admission, Oct. 16, 1962. The patient states she has not felt fatal movement for approximately 5 weeks. No fetal heart beat or placental souffle was heard on admission.

Delivered by cesarean section — Placenta praevia centralis was present. The placenta was nonfunctioning.



Shaded area indicates probable location of placenta.

Interpretation: Scan does not localize the placenta. This would indicate a posterior wall placental site; or a lack of a significant placental blood flow.

M.D.
Department of Radiotherapy

* Please sketch in actual location of placenta at delivery and return to Dept. for purpose of confirmation.

Figure 1.

Patiant Mrs. R.D.R.Rm. 415[2] Age 37 Gravida V Para IV EDC 9 Feb. 63

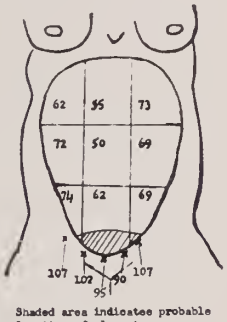
Physician _____ Log No 6 Isotope No 3348-1 IHSA 10 mc Date 1/2/63

History:

Prenatal history reveals an episode of cramps and bleeding in Nov., lasting less than an hour.

Painless vaginal bleeding began on the morning of Jan.1, 1963. Bleeding was heavy enough to require three perineal pads, but then stopped spontaneously.

Delivered by cesarean section— Placenta praevia centralis was present.



Shaded area indicates probable location of placenta

Interpretation: Low lying placenta probably located on posterior wall, with margin at os.

M.D.

* Please sketch in actual location of placenta at delivery and return to Dept. for purpose of confirmation.

Figure 2.

failure to locate the placenta was due either to a reduced blood supply to the placenta or that it was located entirely on the posterior uterine wall (Fig. 1). Vaginal examination was carried out after the patient had been returned to the delivery room area. This revealed the presence of the total placenta praevia, but the examination did not produce any significant degree of hemorrhage. The patient was then transferred to the operating room where a macerated infant was delivered by low cervical cesarean section. Inspection confirmed the diagnosis of total placenta praevia. Examination of the placenta revealed it to be extremely fibrotic with almost no blood supply. The patient's postoperative course was essentially uneventful and she was discharged on the tenth postoperative day.

The other case to be presented in some detail is one in which we feel that the use of the Placentascan was a valuable adjunct in the patient's management. The Placentascan not only made the correct diagnosis, but did so without any risk to the mother or infant.

Mrs. R. D. R., a thirty-seven year old, gravida V, para IV, Rh negative Negro was admitted to the hospital on Jan. 2, 1963 because of painless vaginal bleeding. Estimated date of confinement according to menses was Feb. 9, 1963. The history revealed that the patient had experienced a previous episode of bright red vaginal bleeding in Nov. 1962, which lasted less than one day and was not heavy enough to require a perineal pad. On the day of admission she had required three perineal pads, but the bleeding had stopped spontaneously. Abdominal examination revealed the uterine size to be compatible with the estimated date of confinement. The presenting part was not engaged, and the fetal heart beat was of good quality in the left lower quadrant. Both Placentascan (Fig. 2) and X-ray of the abdomen (Fig. 3) were interpreted as diagnostic of placenta praevia. Conservative management was decided upon by the attending physician.



Figure 3.

and after observation for approximately forty-eight hours, during which no bleeding occurred, the patient was discharged from the hospital.

The patient was readmitted to the hospital on Jan. 15, 1963 because of another episode of painless bright red vaginal bleeding. With blood available, again it was elected to observe the patient, as bleeding was minimal at this time. After approximately twelve hours of observation, because the patient continued to have a small amount of vaginal bleeding, it was elected to proceed with cesarean section. A living healthy six pound five ounce male was delivered by low cervical cesarean section. An excerpt from the operative dictation reads: "The placenta was lying completely in the lower uterine segment with approximately two-thirds of it covering the os of the cervix, the bulk of it lying on the left side. The baby's head was cupped into the placenta." The postoperative course was uneventful, the mother and infant were discharged from the hospital on the seventh postoperative day.

It is important to note that in the management of the last case at no time was the patient subjected to a vaginal examination nor was one necessary to make the correct diagnosis.

Summary

1. The technique of Placentascan utilizing I^{131} tagged human serum albumin is presented, emphasizing its simplicity.

2. The advantages and disadvantages are discussed.

3. The results of our experience in fourteen cases are presented with one case of total placenta praevia being reported in detail.

4. An unusual case in which the location of the placenta could not be detected by Placentascan is discussed in some detail.

Bibliography

1. Browne, J.C.M., and Veall, N. A Method of Locating the Placenta in the Intact Human Uterus by Means of Radioactive Sodium. J. Obst and Gynaec. Brit. Emp. 57:566, 1950.

2. Weinberg, A., et al. Localization of the Placental Site by Radioactive Isotopes. Obst. and Gynec. 9:692, 1957.

3. Hutchinson, D. L., Bennett, L. R., and Gean, D. A. Isotopic Localization of the Placenta in Placenta Praevia. Surg. Gynec. and Obst. 107:370, 1958.

4. Cavanaugh, D., Pose, C. E., and Gilson, A. J. Placenta Praevia: Modern Methods of Diagnosis with Special Reference to Isotopic Placentography. Obst. and Gynec. 18:403, 1961.

Your Participation is Urged

During

National Diabetes Detection and Education Week

November 15-21

A Review and Evaluation of Eight Hundred Consecutive Anesthetics Administered for Cesarean Section Delivery

Ryland Roesch, M.D..* Sprague Gardiner. M.D..** and V. K. Stoelting, M.D.***

Indianapolis, Ind.

A comparison of regional versus general anesthesia for Cesarian delivery indicates that there is no statistical difference in mortality or morbidity associated with either technique; though the "time factor" may be critical.

AMONG those experienced in the administration of anesthesia for Cesarean Section delivery, there is general agreement that the properly managed regional anesthetic is associated with the greatest incidence of vigorous new born babies. Certainly this report does not refute such an impression. However realizing that only sixty-five percent of our Cesarean Section deliveries are conducted under regional anesthesia we felt that an evaluation and comparison of the two techniques (regional versus general anesthesia), as employed at the Indiana University Medical Center, was indicated.

Material

In our series of eight hundred procedures five hundred and twenty-four of the mothers were given regional (spinal) anesthetics. This number represented sixty-five percent of the total (Table I). These spinal anesthetics were associated with a corrected fetal death rate of one percent. Another one percent of the infants delivered under spinal, although surviving, required various degrees of resuscitative activity. In contrast, fifteen percent of the infants in the serics required resuscitation if the mothers received general anesthesia.

Table I.

Total number of cases reviewed	800	
Number of spinal anesthetics	524	65.5%
Number of general anesthetics	268	33.5%
Number of epidural anesthetics	4	.5%
Number of local anesthetics	4	.5%

Two hundred and sixty-eight mothers were given general anesthesia. In consideration of this high percent of infants requiring resusitation, one should remember that the majority of the mothers who were bleeding actively, or mothers whose babies demonstrated severe distress, were delivered under general anesthesia. Thirty-one patients fell into this category of emergency. Twenty-two of these mothers received general anesthesia while only nine of them received regional anesthesia. Thus eight percent of the general anesthetics were given for such emergency situations, while only two percent of the regionals were employed under similar circumstances. (Table II)

Table II.

Cesarean Sections for active bleeding or severe fetal distress	
Total number of cases in this category	31
A. Received general anesthetic (equals 8% of general anesthetics in series)	22
B. Received spinal anesthetic (equals 2% of spinal anesthetics in series)	9

Another facet of this study that interested us was the relationship of time to the incidence of depressed babies. The time factor investigated was the interval between the onset of anesthesia and the delivery of the infant when general anesthesia was used. As stated previously, fifteen percent of all of the babies delivered under general anesthesia required some resuscitative efforts. In those instances in which the baby was not delivered for ten minutes or longer after the onset of anesthesia this percent rose to thirty-four.

However, only nine percent of the babies delivered in ten minutes or less after anesthesia

*Assistant professor, department of Anesthesiology, Indiana University School of Medicine, Indianapolis.

**Professor, department of Obstetrics and Gynecology, Indiana University School of Medicine.

***Professor and chairman, department of Anesthesiology.

had begun required resuscitation. When this time was reduced to six minutes the incidence of babies in need of resuscitation was only three percent. Furthermore, none of the babies delivered in the elective situation, who were delivered within six minutes after induction of anesthesia, required resuscitation. There were sixty-one babies in this category (Table III). Thus babies delivered under conditions similar to those that usually prevail when spinal anesthesia is employed, and who were delivered in less than six minutes after onset of anesthesia, enjoyed the same vigorous physical condition at birth as the babies whose mothers received regional anesthesia.

Table III.

Number of babies requiring resuscitation	
I. General anesthesia	
A. Over-all percent requiring resuscitation	15%
B. Percent when anesthetic lasted less than 6 minutes	3.3%
C. Percent when anesthetic lasted less than 10 minutes	9.1%
D. Percent when anesthetic lasted longer than 10 minutes	34%
II. Regional Anesthesia	
A. Percent of all babies delivered requiring resuscitation	1.1%

The infants involved in this study were not classified by the Apgar method, except in a few instances.[1] Thus it remained for the reviewer to evaluate the babies from the comments on the hospital charts. These comments were made by the anesthesiologist, obstetrician and pediatrician. We gave special consideration to whether or not the baby required resuscitation; and whether subsequent condition of the baby indicated if the baby suffered from any abnormality to which anesthesia or obstetrical management were contributing factors.

Neither an evaluation such as we used or the Apgar score will truly reflect the difference in the condition of newborn babies when one is comparing babies whose mothers received regional anesthesia to babies whose mothers were managed by general anesthesia. Comparison of babies separated into these two categories is confusing, because immediately after birth the baby whose mother received inhalation anesthesia may be temporarily depressed. However, when such depression is the result of the anesthetic agent; adequate ventilation of the infant will reduce the concentration of the drug so that within two or three minutes the baby will be vigorous. On the other hand the baby with an Apgar score of four or five, whose mother has received an uncomplicated regional procedure, probably has some serious anatomical abnormality. Thus, though fifteen percent of our babies born under general anesthesia received some resuscitation, ordinarily such attention was brief and perhaps not always necessary. Almost invariably resuscitation resulted in a good baby.

Table IV.

Infant Mortality Occurring Within First Forty-Eight Hours	
Mothers received general anesthetic	1.3%
Mothers received spinal anesthetic	1.0%

In substantiation of this conclusion, the incidence of babies dying within the first forty-eight hours was one and three tenths percent of the babies born under general anesthesia and one percent of those babies born under spinal anesthesia. Therefore, when one exercises careful selectivity and management of cases, very little difference, if any, separates these two techniques with regard to infant mortality and morbidity.

Technique

The technique we employ for general anesthesia is designed to facilitate reduction of the time interval between induction and delivery. We induce anesthesia, as a rule, with a small dose (40 to 50 mgs) of Methohexital. Because Methohexital is so rapidly metabolized, this small amount of drug is inactivated before the infant can be delivered. We have been very favorably impressed by Methohexital when given to mothers for Cesarean Section delivery. Almost immediately after giving the barbiturate, we administer sufficient Succinylcholine, as a single dose, to immobilize the patient.[6] The surgeon then makes his incision. We rarely give additional Succinylcholine. If intubation is indicated we insert the tube at this time. The majority of our patients are not intubated. From the time the barbiturate has produced sleep the mother is ventilated with a gas mixture containing either dilute Cyclopropane or Fluothane and at least fifty percent oxygen. Although the anesthetic agent is kept very dilute, we attempt to discontinue this mixture and use pure oxygen for at least one minute before delivery.

In preparation for elective Cesarean Section deliveries we do not give narcotics for premedication. We do give anticholinergics to those patients who are to receive general anesthesia. However, those mothers who have been in labor

usually have received a variety of analgesics and sedatives. Of course these drugs will influence the incidence of depressed infants. However, we do not feel that this factor produces any greater number of depressed infants than occurs from the same cause in vaginal deliveries. Used correctly, premedication does not influence significantly the incidence of depressed newborn infants. Instead we feel that the key to our goal of non-depressed newborn infants lies in the use of light anesthesia and expeditious delivery of the infant. The use of muscle relaxants and a rapidly destroyed inducing agent are great adjuncts toward this end.

Frequently when challenged by the obstetrical emergencies resulting from active bleeding, impending shock, or marked fetal distress, we prefer general anesthesia. It may seem a paradox that regional anesthesia is the preferred technique for the elective cases while general anesthesia is the better choice for many of the emergency situations. However, the features of obstetrical emergencies that make time and the avoidance of vasodilitation so vital are responsible for such decisions. Because of this need for different anesthetic techniques, it becomes incumbent upon all who manage patients for Cesarean Section delivery to be able to utilize effectively whichever method would serve the situation better. When not confronted with those conditions outlined, in which we feel that general anesthesia is indicated, we prefer regional anesthesia. This preference has developed because we can provide the surgeon with a situation that is free from the need of speed, relaxation is excellent, and the patient remains awake while being subjected to a minimum of metabolic disturbances. Regional anesthesia is especially desirable for the patient who has had previous Cesarean Section. Frequently these mothers present the surgeon with the tedious task of dissecting bountiful adhesions that distort the anatomy and prolong the procedure. In this series approximately forty percent of the procedures were for "repeat sections".

We experienced one maternal death in this group of eight hundred consecutive Cesarean Sections. This patient suffered from severe toxemia. Spinal anesthesia was employed for delivery. Unfortunately the patient developed nausea and vomiting shortly after being anesthetized. She was given thiopental for this complication. The combination of anesthesia and sedation proved disastrous and the patient died. We have learned from such experiences to avoid ultra short acting barbiturates in the face of toxemia, hemorrhage and prematurity.[7]

Summary & Conclusion

Because of the need for different anesthetic techniques; it is incumbent upon all who manage patients for Cesarean Section delivery to be able to use effectively whichever method will serve the situation better. Our statistics show that a greater percentage of babies required resuscitation when delivery was delayed for six minutes or longer after induction of anesthesia. Although we cannot state that survival of the babies is influenced by this factor, when resuscitation is made necessary; then life depends on the judicious employment of this skill. Therefore, we feel that any technique which decreases the need for resuscitation is wise.

BIBLIOGRAPHY

1. Apgar, Virginia: New York State Journal of Medicine, Sept., 1957.
2. Lund, Peere C.: Journal of American Medical Association, 159: Dec. 24, 1955.
3. Potter, Edith: Journal of American Medical Association, 156: 1471, 1954.
4. Taylor, Stewart: Journal of American Medical Association, 156: 1481, 1954.
5. Hartridge, Virginia: Anethesia and Analgesia 40: 285, 1961. 1961.
5. Moya, Frank and Knisselgaard, Niels: Anesthesiology 22: 1, 1961.
7. Gustafson, Gerald and Gardiner, Sprague: American Journal of Obstetrics and Gynecology 58: 246, August 1949.
8. McKechnie, F.B., and Converse, JG.: American Journal of Obstetrics and Gynecology 70: 639, 1955.

The Role Of A Non-Psychiatric Physician In A Mental Health Program

Harold J. Schupbach, M.D.
Owensboro, Ky.

The physician in practice is in a unique position to lend balance and leadership to a Community Mental Health program. The opportunities for leadership to our communities, our profession and our patients are discussed.

THE past decade has been marked by an upsurge of concern and activity for mental health. Emphasis has been focused on the role of the community in mental health programs. Professional mental health workers have pointed out the inadequacies of custodial mental health care and have demonstrated the advantages and necessities of preventive and therapeutic programs at the community level. The lay public has begun to demand mental health facilities on the same basis as other medical care opportunities. Interested lay groups have sprouted throughout the country to assist in the establishment of local mental health services. The growth of the mental health associations, mental health clinics, child guidance centers, and general hospital psychiatric facilities here in Kentucky provides an illustrative picture of this commitment of the community to the development of mental health resources.

Where in this program does the physician find his place? I am speaking now, not of the psychiatrist, but the generalist, the pediatrician, the internist, the surgical specialist, and all others who have a concern for the relevance of medicine to the community, in fact all physicians whose humane interest and sense of civic pride and social responsibility require some sort of participation in community life.

The AMA Statement of Principles on Mental Health succinctly states: "The physician participates in the mental health field on two levels—as a man of science and as a citizen."[1]

*Presented before the meeting of the Kentucky Psychiatric Association on Tuesday, September, 24, 1963 during the KSMA Annual Meeting in Lexington.

Role as Citizen

Let us first examine his role as a citizen. James Reston, New York Times Washington Bureau chief said, "One of the persistent complaints of decent and intelligent Americans in the postwar period has been that they have felt helpless to do anything personally about the great problems of their country."[2] Physicians of today seem no less given to this sense of futility and frustration than the rest of the public. Yet here in the mental health movement, physicians have before them an outstanding opportunity to exercise leadership and to contribute towards solutions of many of society's problems in a fashion that is particularly compatible with the qualities of individualism, personal responsibility and humanism characteristic of the physician. The reawakening of society's collective concern for the mentally ill, which it had previously conveniently transferred to the state-run asylums, and the commitment of the public to preventive mental health on the community level could and should be an intense stimulus to restoration of the principle of individual and local governmental responsibility in such fields as welfare, child guidance, slums, aging, and other problems created by automation and mass society.

To be more specific, the physician can exercise his natural qualities of leadership by joining with the other citizens of his community to build a mental health program that will effectively meet the needs of his own community. How can he do this?

First, the physician has a unique opportunity to know at first hand some of the pressing needs of his community. The daily encounters of medical practice provide a remarkable barometer of mental health resources. The adequacy of welfare programs should be evident immediately to every physician in a community. A family physician or a pediatrician can answer in a moment whether or not a need exists for a child guidance program or a mental health clinic. An obstetrician should have an informed

opinion about such problems as divorce, teenage promiscuity, or the potential need for a planned parenthood program. From his vantage point, the physician can provide challenges and direction to voluntary and civic organizations in the mental health field.

Aside from simply describing problems and suggesting modes of relief, the physician can also serve effectively on the board of mental health associations, clinics, and other organizations to work actively for solutions to these problems. The esteem and respect with which the physician is regarded in the community can be a positive force for the enactment of the general program of such a group. His presence is necessary for other reasons.

In general, the physician represents a stabilizing influence on the activities of any group working in the mental health field. The motivation of laymen for service in such groups is most often mature and selfless, but not uncommonly, individual members of such an organization may use it as an outlet for personal conflicts and tensions.

The understanding physician can often perform a useful function in preventing such motivation from having a disruptive or disastrous effect on the program of the group. He can help resolve questions of professional ethics and propriety that frequently arise in the activities of the organization. He can be of considerable value as an interpreter and critic and also as an avenue of communication between the group and such specialists as the psychiatrist and social workers.

Another area of immense importance is that of financing mental health activities. The prevailing disapproval of federal monetary largesse should not prevent, in fact, it ought to encourage, the physician to become an active campaigner for local financial solutions. Demands for services will grow. A tremendous campaign backed by our own AMA, by the President and Congress, by the National Association for Mental Health, and by the growing sophistication of people at large has resulted in a clamor for new services. The AMA supports the principle of "multiple source financing for community mental health sources and accepts the need to expand this financing, as well as expenditures for state and federal hospitals."[3]

Fund raisers with their varied obligations tend to look in all directions in order to establish their programs. An uninformed, indifferent, or miserly attitude on the part of municipal, county, and state officials may result in federal financing by default for many projects that could be supported adequately locally. The physician often knows personally the city and county officials and state legislators. It is mandatory that physicians support rational programs to pay for new services and to campaign for local financial responsibility if pork barrel financing is to be avoided. In the field of patient care for mental illness, the physician through our national organization must also work for expansion of voluntary prepayment plans for mental illness on the same basis as those designed for medical and surgical care.

The physician dedicated to the promotion of mental health activities has an important obligation to interpret the program to the medical profession at large. Increasingly today, the profession is sensitive to the inroads of governmental agencies in the health fields to the point that we are inclined to be suspicious of any project that involves health services provided by public agencies. In actuality, many of the services in the mental health field can be provided only by cooperative public effort; for example, the mental health clinic, school guidance program, or the care of the chronically insane.

In other instances, a combination of public and private responsibility may solve mental health needs, such as proposed regional psychiatric treatment centers designed to avoid costly duplication and isolation and making possible the care of both public and private patients. Still other situations will require protection of time-honored private relationships such as that of the patient and his physician. The informed and interested physician is the logical person to interpret this variety of programs to his colleagues.

Role as Physician

It is time for a few words about the scientific or professional role of the physician in the mental health program. It is increasingly evident that psychiatrists alone cannot in any way begin to meet the mental health manpower needs. An immense increase in our understanding of the cause and mechanism of disease, followed shortly thereafter by the development of specific drugs for so many of these diseases, has led to a certain preoccupation with organic disease. These brilliant discoveries, coupled with the isolation of mental illness from view, the inability to fit it into convenient organic or bio-

chemical frameworks, and the lack of effective treatment, resulted in a general disregard for emotional illness.

Happily, this attitude has been replaced by a healthy interest on the part of the physician for the emotional welfare of his patient. He has found he can modify or remove anxiety and depression with drugs. He often has a better comprehension of the psychodynamics of a particular ailment than the psychiatrist of an earlier generation. He has begun to treat emotional illness with increasing confidence and success, and psychiatrists have begun to lend their support and encouragement to such efforts.

How far this process will extend cannot be foreseen, but strict limitations have no place here. Increasingly, the non-psychiatric physician is being granted responsibilities commensurate with his interest, training, and ability, even in hospital psychiatric services.[4] In private practice, he has often willingly, occasionally reluctantly, but always pressed by the overwhelming need, accepted the role as therapist for the less serious emotional disorders. At the same time, the competence of the non-psychiatric physician as a therapist has steadily increased as a result of postgraduate education and experience.

The physician in general has other obligations. His intelligence, good will and foresight are necessary in the hospital staff organization whenever it sets about in an attempt to provide psychiatric treatment services or improve upon old patterns of care. It is also important that he provide consultative services in his own special field for the benefit of his psychiatric colleague. Furthermore, he can help break down walls of distrust and aloofness that have sometimes marked the relationship between clinical medicine and psychiatry, to the profit of all concerned.

REFERENCES

1. AMA Statement of Principles on Mental Health, June 1962 (AMA pamphlet).
2. James Reston, The *New York Times*, June 23, 1963.
3. Program of the AMA Council on Mental Health, JAMA, 181: 1080-1085.
4. Open Staffs in Psychiatric Hospitals and Services, Supplement, Mental Hospitals, October 1961.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

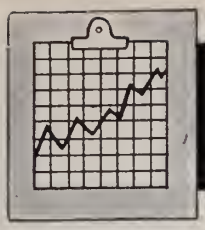
Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

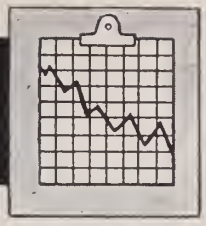
Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.



CASE DISCUSSIONS
From The
University of Louisville Hospitals



Case Report — Tetanus

DONALD M. THOMAS, M.D.*

A 21-year-old white male farm worker sustained a minor wound of the left hand on 5-23-64. This healed in three days with no treatment. On 6-1-64 he noticed some difficulty in opening his mouth and in chewing. This increased on 6-2-64 and severe backache developed, but the patient worked all day on 6-2-64. Symptoms of trismus and backache were severe enough on 6-3-64 to cause him to seek medical attention. His physician made the diagnosis of tetanus and referred the patient to Louisville General Hospital for treatment.

Examination on admission to the Neurology Service on 6-3-64 showed a well developed male with marked trismus. There was difficulty with swallowing and phonation. He was very irritable. Vital signs were as follows: blood pressure 130/70, pulse 80, respiration 20, temperature 100°. There were no other significant findings.

The already healed wound on the hand was excised with a 1 cm. margin and left open, and 2,000 units of tetanus hyperimmune globulin were given. Sedation with phenobarbital 100 mgm. and chloropromazine 25 mgm. intermuscularly every four hours was begun. Oral intake was stopped and the patient maintained on I. V. fluids to which 6 million units of aqueous penicillin were added every 24 hours.

During the first 24 hours in the hospital, tetanus spasms increased in intensity, duration, and frequency. Respirations became labored, and a tracheotomy was done late on 6-4-64 with some improvement. During the morning of 6-5-64 he was almost constantly in muscular spasms with great respiratory difficulty. The Anesthesiology Service was consulted and the patient was transferred to the recovery room at noon on 6-5-64.

He was immediately started on intravenous infusions of 0.5% thiopental for sedation and 1.0% succinylcholine for muscular paralysis. Respirations were maintained by the Morch piston respirator. Neuromuscular blockade was maintained more or less completely for eight days, except for a brief period daily when the block was allowed to wear off so that the patient's disease could be evaluated. Sedation was maintained using either a continuous infusions of 0.5% thiopental or a combination of intermittent intravenous injections of pentobarbital 100 mgm. and morphine sulphate 10 mgm. The method of sedation was changed on alternate days in an effort to prevent the development of tolerance to any particular drug.

On the ninth day of treatment, neuromuscular blockade was discontinued for twenty-four hours and the patient tolerated several brief periods off of the respirator. However, there was increasing muscular spasm and respiratory difficulty and neuromuscular block was re-instituted for several hours during the tenth day of treatment. After this neuromuscular blocking agents were discontinued. A total of 120 grams of succinylcholine and 25 grams of thiopental were used during this ten day period of intensive treatment.

On the eleventh day, sedation was changed to phenobarbital 100 mgm. every four hours I. M. and pentobarbital 100 mgm. every three hours I. V. At this time, appropriate stimulation would still elicit tetanus spasms but these were mild and of very brief duration. By the twelfth day, he was able to sit up briefly and drink a few sips of water. There were still some spasms.

On 6-18-64 the thirteenth day in the recovery room, sedation was changed to chloropromazine 25 mgm. and phenobarbital 100 mgm. every six hours and paraldehyde 5 ml. I. M. for restlessness. This regime was very successful in controlling spasms, and weaning from the respirator was begun and completed on 6-19-64. On 6-20-64 a liquid diet was begun and the patient ambulated briefly. Sedation was reduced to phenobarbital 75 mgm. and chloropromazine 25 mgm. every six hours on 6-20-64 and every eight hours on 6-21. On 6-22 the patient was able to eat a soft diet and the tracheotomy tube was removed. He was discharged from the hospital on 6-29-64.

Little difficulty was experienced during the management of the patient. Of greatest concern was a left lower lobe pneumonia first diagnosed on the evening of 6-5-64 when his temperature reached 103°. Chloromycetin 2 gms. intravenously every 24 hours was begun. Chloromycetin was reduced to 1 gm. daily on 6-12 and discontinued on 6-18-64. Penicillin was discontinued on 6-9. The only complication of the antibiotic therapy was a diarrhea which began on 6-18-64. This was easily controlled by restoring the intestinal bacteria with buttermilk given on 6-19-64 via a nasogastric tube.

No oral or tube feedings were given prior to 6-19-64, the patient being maintained on I.V. fluids. He was kept very well hydrated to help keep tracheobroncheal secretions thin and easy to control. No difficulty was encountered with electrolyte or acid-base balance.

Assistant professor of anesthesiology, University of Louisville, School of Medicine.

Discussion

The management of the patient with tetanus continues to be a problem. This is not only because of the severity of the disease, but few physicians or institutions see enough patients with tetanus to become really familiar wih the disease and its treatment. The case fatality rate for tetanus is generally stated to be close to 50%. In centers where substantial numbers of cases are seen, this is reported reduced to 25 to 35%,[1] still an alarmingly high figure.

The present case may be regarded as fairly typical of traumatic tetanus. The initial wound was trivial and was not treated. The patient had never been immunized against tetanus. The incubation period was about seven days, and the onset of symptoms with trismus and backache represents the most common early complaint of these patients.

There are three objects in the treatment of tetanus:

1. Eradication of the focus of infection
2. Neutralization of any circulating toxin
3. Control of spasms with maintenance of adequate respiration.

In the case under discussion, eradication of the focus of infection was achieved by surgical debridement of the wound and the administration of high dosage penicillin therapy to kill any remaining organisms.

Tetanus antitoxin is used to neutralize any circulating toxin remaining after eradication of the infecting organisms. Toxin already fixed to the nervous tissue however, cannot be neutralized. The availability of human tetanus hyperimmune globulin has greatly simplified the problem of adequate antitoxin therapy in these patients. The single dose of 2,000 units is adequate for therapy of tetanus, 150-250 units may be used for prophylaxis.[2] The advantages of human hyperimmune globulin have been reviewed and include a higher and longer maintained antibody titer in the serum and the elimination of reactions to horse or bovine serum. If hyperimmune globulin is not available, a single dose of 50,000 units of equine or bovine antitoxin has been shown to be as effective as larger doses.[3] Repeated injections of horse serum antitoxin are definitely contraindicated.

The chief controversy in the management of tetanus generally concerns the method for control of spasms. The majority of deaths from tetanus are respiratory in nature, and are the result of airway obstruction during spasm, aspiration, interference with adequate respiratory exchange by severe muscle spasms or respiratory depression from over zealous use of sedatives and muscle relaxants.

Tracheotomy is almost always necessary, and is better performed early under optimum conditions in the operating room than as a last-ditch bedside procedure. Therefore, it is suggested that tracheotomy be routinely performed at the time of surgical treatment to the wound of entry. This was not done in the present case, and pneumonia was the result.

A variety of regimens for control of spasms is advocated in the literature. Sedation with barbiturates and chloropromazine is widely used. Others use such agents as mephenesin, meprobamate, or methocarbromal, either alone or combined with barbiturates. The use of these agents is based on their action as central muscle relaxants or "internuncial" blocking agents.

A third group advocates more or less complete neuromuscular blockade with peripherally acting myoneural blocking agents such as d-tubocurare or succinylcholine. We elected this procedure because as anesthesiologists, we are familiar with the use of these drugs, and because barbiturates and chloropromazine had failed to give adequate control. The use of continuous artificial ventilation if essential with this method, and neuromuscular blocking agents should never be used without it.

The major hazard in the use of complete paralysis is that it places the patient completely at the mercy of those who are taking care of him. Nursing care is all important. This method cannot and should not be undertaken unless an experienced around-the-clock nursing unit familiar with the use of respirators and the management of completely helpless patients is available. If a recovery room or intensive care facility is not available, management by some means not involving neuromuscular blockade is preferable. When adequate facilities are available, however, the methods used in the present case produce excellent results and have the advantage that the incidence of pulmonary complications will be minimal.

The pathology and management of tetanus has been the subject of a recent excellent review[4] which the reader may wish to consult for further information.

Bibliography

1. Hewitt, R. L.; Wren, H. B.; Krementz, E. T.: *Recent Trends in Tetanus.* Arch. Surg. 88: 768-773 (May) 1964.
2. McComb, J. A.: *The Prophylactic Dose of Homologous Tetanus Antitoxin.* N. Engl. J. of Med. 270: 175-178 (23 Jan.) 1964.
3. Vakil, B. J.; Tulpule, T. H.; Armitage, P. and Laurence, D. R.: *A Comparison of the Value of 200,000 I. U. Tetanus Antitoxin with 50,000 I. U. in the Treatment of Tetanus.* Clin. Pharm. Therap. 4:182-187 (Mar.-Apr.) 1963.
4. Laurence, D. R. and Webster, R. A.: *Pathologic Physiology, Pharmacology, and Therapeutics of Tetanus.* Clin. Pharm. Therap. 4: 56-72, (Jan.-Feb.) 1963.

SPECIAL ARTICLES

Physicians and Hospitals — Partners on the Health Team†

MILFORD O. ROUSE, M.D.*

Dallas, Texas

IT IS a great pleasure and a personal privilege for me to bring you warm greetings from the American Medical Association, its officers, and all its members. Physicians and hospital administrators are truly partners on the health care team, and I have looked forward with happy anticipation to meeting and talking with you.

It is no secret to anyone in this audience, or to most Americans today, that the American Medical Association is waging an all-out legislative campaign to preserve that system of medical care which insures the best quality possible. It is no secret that many physicians, like myself, and many hospital administrators, like yourselves, are devoting a great deal of time and effort to keep medical care by physicians and hospitals out of the hands of the federal government.

When one critically examines the King-Anderson bill, it is clear that its passage would place substantial power in the hands of the Secretary of Health, Education and Welfare. He would preside over a centralized, bureaucratically-administered program with great power to control administration of the nation's hospitals and to regulate the practice of medicine in your institutions.

He would be empowered to promulgate regulations imposing conditions on hospitals that the community might not want to accept. But once a contract has been signed for participation in the program, the hospital would have no choice to obey or withdraw. Hospitals might find addiction to the program easy. However, once they become dependent upon it for funds, withdrawal would be difficult.

We have been teammates in the legislative campaign to defeat the King-Anderson bill, and I would urge earnestly that this effort be strengthened. President Johnson has clearly demonstrated his determination to enact this measure. As a fellow-Texan, I know that we can never underestimate the President's legislative know-how.

In addition to our joint opposition to the King-Anderson bill, we have worked together in implementing and improving the Kerr-Mills program. We have sent teams to the state and federal level to work out the smooth functioning of this program of health care for the needy and near-needing aging. Because of our efforts, 38 states and four jurisdictions have enacted the Medical Assistance to the Aged portion of the law, and all of the states and jurisdictions have implemented the vendor payment medical programs for Old Age Assistance recipients. This progress has been one of our cornerstones in opposition to King-Anderson.

Health Insurance and Prepayment Plans

We have also worked as a team in providing health insurance and prepayment plans for senior citizens. Today, about 10 million elderly Americans have protection from the cost of illness or accident. This is well over half the over-65 population which has prepared to meet its individual responsibilities without recourse to a gigantic federal aid program. The fact that private enterprise has succeeded in finding the means to enable these citizens to stand on their own is another major reason why King-Anderson is both unnecessary and undesirable.

AMA Objectives

Some of those favoring the King-Anderson bill attempt to make it appear that the AMA House of Delegates, its councils and committees, and its staff have dropped everything else to fight this proposal. Actually, the AMA is engaged in a wide variety of activities and programs. All of them are aimed at fulfilling the association's two objectives: To promote the science and art of medicine and the betterment of public health. I want to emphasize that our opposition to the King-Anderson bill is also based on our pursuit of these two objectives.

The bulk of our activities deal directly and indirectly with the provision of the highest quality of medical care possible to all patients by all physicians in all hospitals throughout the nation.

The AMA's Council on Medical Education, Internship Review Committee, Residency Review Committees, Council on Medical Service, Committee on Medical Facilities, Committee on Insurance and Prepayment Plans, Council on Scientific Assembly, and

†*Presented before the 35th Annual Meeting of the Kentucky Hospital Association held April 1, 1964 in Louisville.*

**Speaker, House of Delegates of the American Medical Association.*

the AMA Commissioners on the Joint Commission on Accreditation of Hospitals are but a few of our groups working directly in this area.

Today, we not only want to stimulate, encourage and participate in the establishment of the finest hospital facilities to insure this high quality patient care, but we also seek to promote and strengthen the voluntary control of physicians and hospitals.

Physicians today know that without a hospital their effectiveness in dealing with serious disease and injury would be curtailed sharply. At the same time, it is recognized that without physicians, hospitals could not serve patients.

So it is this partnership of physician and hospital in providing excellent health care to the American people that gives hospitals their real purpose. Teamwork, cooperation and understanding between physicians and hospitals are imperative if the best possible care under the voluntary system is going to continue to work and to improve steadily.

Cooperation in Kentucky

I am happy to note that the Kentucky State Medical Association and the Kentucky Association have cooperated on a number of items which have contributed to a higher quality of medical care in the state.

— The KSMA Hospital Committee, working with the KHA Committee and the medical record librarians, developed a guide for the release of information from medical records.

— The KSMA Hospital Committee, working with corresponding agencies of KHA and the librarians, established teams to make dryrun inspections of medical records in a number of hospitals.

— Kentucky was the first state, or certainly among the first, to develop a manual for hospitals seeking accreditation and a manual for the use of "dry-run" team members doing the inspection.

— The KSMA Hospital Committee and the Kentucky Hospital Association have cooperated in working with hospitals that have had problems which could best be solved by receiving the joint attention of the medical and hospital organizations.

— KSMA and KHA have worked together on the transfer of United Mine Workers Hospitals to the Appalachian Regional Hospitals, Inc., group.

In my opinion, this is a splendid record of cooperation at the local level in overcoming specific problems.

Physician-Hospital Responsibilities

It is clear that physicians and hospitals have tremendous duties and responsibilities now and in the future. Specifically, I believe that:

— Physicians must assume the major responsibility for the quality of care in all medical services provided in the hospital.

— They must assume the major responsibility for recruiting well-qualified physicians for the hospital's medical staff.

— They must take the responsibility for providing the leadership in the establishment and continuation of tissue and medical audits.

— Physicians and hospitals should continue to develop and maintain close liaison between the professional staff and the board of trustees as well as the administrator.

Problem Areas

Medicine has always had its share of problems—scientific, socio-economic, ethical. By its very nature, medicine will continue to be faced with thorny issues that try the patience of all parties involved. However, our record in facing and resolving these problems and in providing improved care to patients has been good, and will so continue.

We have some problems in the area of physician-hospital relations, but I want to emphasize that we know our differences can be solved if we recognize certain basic principles and approach these problems with a spirit of cooperation and understanding.

Physicians Offices In or Adjacent to Hospitals

Physician's offices in or adjacent to hospitals is one area of controversy. At the Annual Meeting of the AMA in 1958, Resolution No. 32 introduced by the Illinois delegation was adopted by the House of Delegates. The resolve stated that the matter of physicians' offices in or adjacent to hospitals "be directed to the attention of the American Medical Association with a request that a study be made to determine whether or not the growing practice by hospitals of encouraging staff members to conduct their private office practice within or adjacent to the hospital is a major move toward the practice of medicine by hospitals."

The Board of Trustees referred this resolution to the Council on Medical Service for study and report to the House of Delegates. At the Clinical Meeting of the AMA in December 1960, the Council reported that "in the light of data presently available, the trend toward locating physicians' offices in or adjacent to hospitals does not at present constitute a major move toward the practice of medicine by hospitals.

The survey has shown, however, that there are objections to this trend on the part of a sufficient number of physicians to make it apparent that continuing study and periodic re-evaluation are necessary."

Unfavorable comments by physicians to this practice were:

1. It interfered with the free practice of medicine, producing factions and cliques within the profession.
2. It is discriminatory in favor of physicians with in-hospital offices, giving them an advantage in use of hospital facilities.
3. It tends to encourage overuse of hospital service such as X-ray and laboratory.
4. It may lead to some hospitals entering into the practice of medicine.
5. It places tax-exempt institutions such as hospitals in direct competition with private real estate interests.

There were, of course, favorable comments—among these that it enables physicians to provide better medical service because of more ready access to diag-

nostic tools and consultants; it enables physicians to have more influence in hospital policies; and it permits more efficient use of the physician's time.

In the opinion of the Council on Medical Service, then, this is a potentially serious problem. If hospitals expand existing facilities to include more and more outpatient services, and if these arrangements between hospitals and physicians encourage the practice of medicine by hospitals through control of services rendered, serious problems may arise.

The suggestion has been made by some hospitals that physicians who utilize hospital facilities should pay to the hospital a percentage of fees which they receive from their patients while being cared for in the hospital.

The Judicial Council has many times expressed itself on the subject of fee splitting. It has stated that the suggested proposal is clearly a case of splitting or sharing professional fees with a lay organization which should not render professional services in the first place.

The Council also pointed out that such proposal increases the cost to the patient who is already being billed for hospital services because the physician will add the tax imposed on him to his bill to the patient.

I might add that the American Hospital Association agreed in 1958 that "it is improper in principle to assess the members of the medical staff on a compulsory basis for the day-to-day operation of the hospital."

Physician-Hospital Relations

The relationship between the hospital and the physician-specialist — pathologists, radiologists, anesthesiologists, psychiatrists, and others—is all too often the basis for poor relations. Many physicians believe that the practice of these specialties should be engaged in by physicians as individual practitioners and not as salaried employees of hospitals.

The American Medical Association is presently reviewing its position on this matter. We are mindful that the number of specialists employed by hospitals is increasing. At the same time, many physicians can see that this situation has certain inherent problems. At this point, I can only say that we hold firm to these principles:

—The physicians must have the ultimate authority and responsibility for *medical* care in the hospital.

—No third party should sell services of the physician for its profit.

For the best interest of physicians and hospitals, I am convinced that we must work out these difficult guidelines peacefully together. We know more about the problem and what is at stake, so let us work together.

Emergency Departments

We are well aware that visits to the emergency departments of hospitals have increased greatly in the past 15 years. Some hospitals have not been able to staff the emergency room adequately and have been forced to employ physicians to staff it.

In many instances, it is essential for the hospital to have salaried physicians in the emergency department. However, hospitals can go overboard on this matter, thereby raising real problems with the physicians in the community. I would urge that all hospitals work together with the local medical society to arrive at mutually agreeable arrangements, based on the two principles I just stated.

Physician, Trustee, Administrator Relations

The top management triangle—physician, trustee, administrator—in the voluntary hospital is susceptible to many conflicts unless there is understanding and cooperation by the three groups.

In recent years, an increasing number of successful businessmen, financial experts, lawyers, engineers, and other professionals participate as trustees of hospitals. This development is excellent because the course should be charted in part by people who have demonstrated ability in the business world.

The hospital administrators are setting higher standards of education and excellence. This, too, is a key factor in improving the performance of hospitals.

Needless to say, physicians are better trained today than most of their predecessors and have the diagnostic and surgical tools and the drugs to provide better medical services.

So, it appears that all three of these elements are equipped to be more effective; and, yet we do have some problems.

In this situation, it is important to all concerned that the role of each group is clearly defined and understood by all members of the top management triangle.

Physicians are the only ones who can engage in *the practice of medicine*. It is equally clear that physicians in the "purely professional" aspects of their practice, cannot be subject to control by laymen. The physician must have freedom to practice. At the same time, he must be subject to certain hospital procedures; and the mechanisms needed to achieve this state is to have communications channels that are formally authorized between representatives of the medical staff and the governing board.

The Joint Commission on the Accreditation of Hospitals has recognized this fact and has stated that there should be a common ground on which the medical staff and the governing board can meet in order that there may be mutual understanding. The Joint Commission has added that a suitable medium for this interchange of information and discussion is the Joint Conference Committee, made up of the members of the governing board and the medical staff.

In addition to this Joint Conference Committee, I believe more governing boards should have physician representation. The AMA Committee to Review the Function of the Joint Commission on Accreditation of Hospitals reported in June, 1956, that it believes staff representation on the governing boards of hospitals is desirable, and recommended that the Joint Commission encourage such representation. The Committee also urged medical staffs to request their boards

of trustees to accept medical members, even if they serve only as non-voting members.

The governing board must not be just window-dressing and a front for fund raising. It is the obligation of the board to keep informed and to exercise its authority. Regular and called meetings are necessary so that the administration and medical staff, through an elected representative or committee, can make reports regarding the various departments and services.

It is clear that the hospital administrator is one of the key persons in the solving of administrative problems which arise in the hospital. The administrator must "operate a tight ship." He should be firm but fair with those over whom he has authority. He must be economical, but wise in his economies—cutting out the frills but preserving the essentials.

He is the agent of the hospital's governing body. He is given power which he must use with discretion. He is managing an empire—an empire of and for others.

Professor Paul J. Gordon of the Graduate School of Business at Indiana University, who made a study of hospital organization, summed up the role of the administrator in this fashion:

"Like administrators in other lines, the hospital administrator can be most effective in the role of consultation, persuasion, negotiation, intergration of diverse interests, etc., and in relating his effort and the work of others to the main objective of the organization."

The administrator of a modern hospital has a complicated technical assignment, and I believe that you administrators are performing an invaluable service to the medical staff, to the governing board, but more importantly, to the patients who come to your institutions.

Area-Wide Planning

The concept of area-wide planning of hospitals and related facilities, while not new, has received considerable emphasis during the last five years. This is another area in which physicians and hospitals must work together as a team.

The conference sponsored by the American Hospital Association and the Public Health Service has brought together representatives of the state and metropolitan hospital associations, the American Medical Association, and other related groups and agencies having a direct interest in the planning for hospital facilities and services.

As a sequel to these activities, the American Medical Association's House of Delegates in 1962 recommended that the medical profession demonstrate cooperation and exert leadership in the formulation and operation of regional hospital planning bodies.

The importance of the physician's role is recognized by the Public Health Service in its most recent document which outlined procedures to implement the techniques of area-wide planning for hospitals. It states very definitely that endorsement of the planning effort should be sought from state and local medical societies while the planning agency is still in the formative stage.

From the preliminary results of our Committee on Medical Facilities study, it is evident that the successful area-wide planning programs have had physician-hospital-public health service cooperation.

Cost of Medical Care

The cost of medical care is a matter of great public concern today, and I am convinced that we must work together in this problem area. We must promote a better understanding of what has occurred in the area of medical care costs, and we must work together to keep medical care prices at a level where services will be available to the overwhelming majority of the people.

In 1960, the American Medical Association established the Commission on the Cost of Medical Care. It assigned the Commission the task of examining the factors which affect medical care prices, the total amount spent by the public for medical care, and the availability of the various services which constitute medical care.

The report will be completed in June 1964; and we anticipate that it will be significant. A major project of the Commission is on the "Changing Patterns of Hospital Care." The study is based on the hypothesis that advances in medical science and technology and a variety of other influences, have resulted in significant and measurable utilization if, and therefore expenditures for, hospital service. Medical care histories for the year 1946, 1954 and 1961 are being gathered from 64 cooperating hospitals. It is anticipated that 34,000 patient records will provide the basic data for this study.

As part of its final report, the Commission will present "Conclusions and Recommendations", based on its four-year study. I hope all of you will take time to read the Commission's report when it is released, and that you will work with us in implementing, wherever possible, the recommendations of the Commission.

Conclusion

In conclusion, let me say that we have made remarkable progress in our hospital facilities, elevating standards of patient care, and in gaining wide public acceptance of the various voluntary mechanisms for financing medical care. None of this would have been possible had we not worked as a team. It is imperative that we continue our joint efforts so that we can provide the best medical care possible outside the interference of the political football field.

EDITORIALS

The Party Platforms

THERE is no doubt that television has added a new dimension to national political conventions as indicated by the number of people who watched the proceedings of the recent conventions.

Many Kentucky physicians, when their time permitted, watched with interest the unfolding drama of the conventions. As one viewed the activities it was apparent that one of the most vital of the convention activities was the development and formulation of the respective party platforms.

Some physicians may not be fully aware of the fact that representatives of the American Medical Association met with the platform committees of both the Republican and Democratic Parties. In each instance there was presented an outline of a health care program which would truly serve the nation's pressing needs in the years immediately ahead. Doctors R. B. Robins and Edward R. Annis presented the program to the Democratic National Platform Committee and the late Doctor Norman A. Welch to the Republican Committee. These physicians expressed the policies on medicine and health which they felt reflected the opinions of a majority of the 200,000 AMA members, who in turn constitute more than 80 percent of the physicians in this country.

The speakers for the AMA emphasized the non-partisan nature of the AMA program. They first presented the story of medical progress in the last quarter of a century and indicated that the medical progress in our nation thus far had to a large extent been made possible by the American system of freedom, individual initiative and personal responsibility.

The speakers for the AMA pointed out that there are areas where federal help can be employed to supplement state and community efforts to care for the helpless, strengthen public health and spur future medical progress. One of the areas is the matter of water and air pollution in the rapidly multiplying and congested urban centers.

The AMA also urged accelerated efforts to overcome mental illness. This would involve the mobilization of government at all levels plus private resources, to fight mental illness as well as mental retardation.

The AMA program endorsed the concept of federal research grants in the field of the communicable diseases, and pointed out that such grants could make a valuable contribution to the national well-being. The Hill-Burton program for hospital construction and federal grants for the construction and modernization of medical schools on a one-time matching basis were endorsed.

The speakers for the AMA indicated again their vigorous support of private health insurance and prepayment plans to enable self-supporting Americans to protect themselves from illness costs. Federal policies were endorsed which would encourage commercial carriers to continue to develop sound coverage plans for the senior population. It was pointed out that the enactment of a federally financed program would undermine the private insurance industry.

The AMA statement also pointed out that the Kerr-Mills plan fits the traditional pattern of other assistance programs, that is, federal financial contributions but state control and state determination of what is required to discharge government responsibility to its citizens. To quote from the AMA program: "the self-supporting are taking care of themselves, protected from illness costs through insurance; the needy are being helped by joint federal-state efforts. Surely the answer to the problem of providing health care for those aging who cannot take care of themselves is not a blanket welfare program which would impose a new tax burden on wage earners and employers to purchase health care indiscriminately for everyone over 65, the wealthy and self-supporting along with those truly in need."

It was pointed out that medicine is a science that has flourished best in freedom and that artificial and unnatural barriers may be raised

between physician and patient in the name of humanitarianism.

Albert Camus, the French writer, wrote in 1953, "We shall be sure that freedom is not a gift received from a state or a leader but a possession to be won every day by the effort of each and the union of all." Freedoms once lost are difficult to regain.

WALTER S. COE, M.D.

Dangerous Drugs

MANY physicians today are concerned with the problems of medication control. Who should be in the driver's seat so to speak to effect an adequate control and at the same time not create difficulties for the patient who would suffer or profit in the long run.

Everyone knows that drugs of all types have some danger connected with them from time to time depending upon variable circumstances and factors inherent in the drugs themselves as well as certain reactions that are the result of the differences in individual patients.

The recent problem in regard to the removal of Parnate (Tranylcytromine) by the United States Food and Drug Administration points up the problem very succinctly. As with other drugs that have come under consideration by the FDA Parnate did cause some difficulty among patients to whom the drug was administered, but as has been pointed out in numerous articles, compared to the number of patients taking the drug the problems were of a minimal nature. This does not mean that these cases should not have been given prompt attention; rather, the knowledge gained therefrom could have been wisely utilized.

It seems at this time that we could learn from this experience in removing Parnate from the market. It behooves us to try to work out some reasonable approach so that the patient can be protected but not be discriminated against because of fears and anxieties in regard to the use of drugs. It seems that we should all support the efforts of establishing a committee of medical scientists independent from both the government and manufacturer to which such matters can be referred for evaluations of safety. In this way the private practice of medicine can function more adequately and feel more comfortable in knowing that the drugs are bereviewed in a more objective manner.

LOUIS M. FOLTZ, M.D.

It's That Time Again

NO physician should forget or neglect to vote; yet with the pressure of other affairs which at the moment seem more important we often fail to exercise the privilege. We tend to forget that it constitutes the very foundation of our republic and that no other country on earth enjoys so free a use of the ballot as do citizens of the United States.

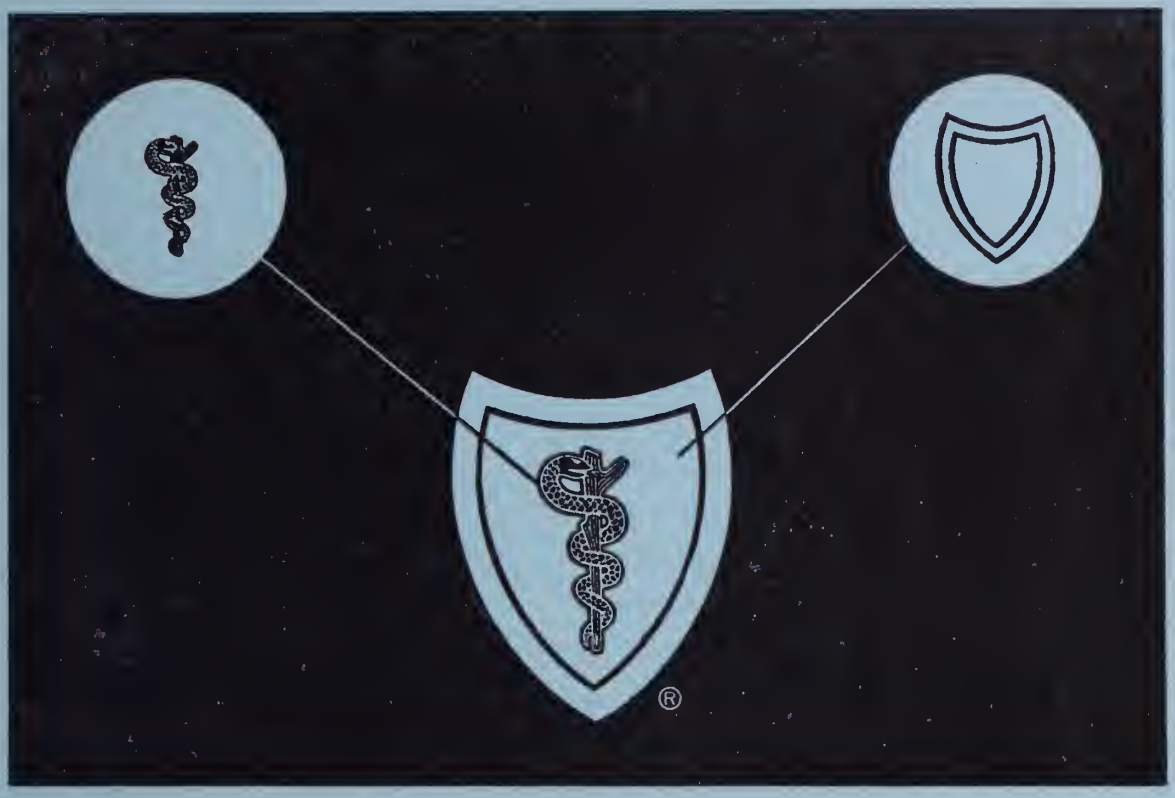
This year we have a very clear choice between candidates for the presidency who profess and practice a widely different philosophy of government. We may have thought the political conventions were prolonged and tedious, as in fact most people claim them to have been. They did, however, outline for each party a fairly well defined policy on domestic and foreign interests. These platforms are generally so different that one may exercise a clear choice as to his preference.

The statement on medical care is clearly defined. The Democrats state they will continue to fight until they have succeeded in including hospital care for older Americans in the Social Security Program and have insured adequate assistance to those elderly people suffering from mental illness and mental retardation. The Republicans state their policy as a pledge for full coverage of all medical and hospital costs for the needy elderly people financed by general revenues through broader implementations of federal-state plans, rather than a compulsory scheme covering only a small percentage of such costs for everyone, regardless of need.

Were our choice based solely upon this portion of the platform, it would not be difficult for us to decide. There are other pertinent issues, however, which we must assess; but make a choice we should, and express our preference at the ballot box.

SAM A. OVERSTREET, M.D.

BLUE SHIELD — a voluntary plan of prepayment, organized by doctors, for people, to help them budget in advance for services.



THE BLUE SHIELD EMBLEM

1. Use of the Aesculapian serpent as a health symbol derives from the ancient belief that a snake renews its life when it sheds its skin.

   Son of the god Apollo and the Thessalian princess Coronis, Aesculapius was the first physician of Greek and Roman mythology. His constant companion was a serpent possessing magical abilities.

   As a young man, Aesculapius raised Hippolytus from the dead, thus angering Pluto, god of the underworld. At Pluto's request, Aesculapius was killed with a bolt of lightning, but the physician then was allowed to join the company of the gods.

   Temples erected in his honor became "health spas" of their time. Pilgrims seeking relief from illness would make offerings, bathe and sleep. During slumber, temple snakes were reputed to work medical miracles. Their actual contribution probably was in ridding buildings of rodents. Daughter to Aesculapius was the goddess of health, Hygeia, from whose name several modern terms are derived.

   The United States Department of Health, Education and Welfare uses the Aesculapian serpent as a symbol.

2. The shield in the Blue Shield means protection. Combined with the Aesculapian serpent, it indicates the protection of medical knowledge.

BLUE SHIELD IN KENTUCKY

DATA PROCESSING HELPS HANDLE INCREASING WORK LOAD

A 1401 IBM magnetic tape data processing unit has been installed by Blue Shield-Blue Cross to handle the constantly increasing number of members and claims; to provide better and faster service to members, doctors, hospitals, and firms; to provide better claims control; and better storage of records.

This machine is a fantastic piece of equipment. It will:

.....Print 600 lines per minute.

.....In 11½ ten thousandths of a second carry a number to the nth power.

.....Store information on 800 Service Reports per minute.

.....Supply information to Claims Department at 200 claims per minute.

.....Sort and write detailed list on every doctor's service report for a period of one year in eight (8) hours time.

.....Process 28,000 transactions a day.

.....Prepare any special report within 36 hours.

.....Multiply at the rate of 2½ hundred thousandths of a second per digit. Any figure can be multiplied or divided by a 4-digit figure in 10 milli-seconds. The average percentage is figured in 8 milli-seconds.

.....Change entire Blue Cross-Blue Shield information on 2500 companies in 4 hours.



FUNCTIONS

.....Examines complete record of every subscriber daily.

.....Processes every contract change and every claim on each subscriber daily.

.....Furnishes complete information to all departments (including Claims Department) to assure proper payment of claims.

.....Processes an average of 1,100 Blue Shield service reports a day.

.....A remittance advice is prepared for each doctor weekly, stating the patient's name and amount paid for him and the date of service. A check is then issued for the total of the remittance advice.

.....Issues approximately 8,000 group and 36,000 individual bills a month.

.....Supplies information on the status of all claims and all subscribers' contracts. (Complete information on every member is available for a period of two years.)

.....Prepares Monthly, Quarterly, and Annual Reports as required by Blue Shield and Management.



ELECTRONICS AID IN STUDIES

With the use of the new electronic equipment of Blue Shield-Blue Cross, many studies can be made which will be helpful to doctors, members, hospitals, and the community at large. Studies can be made on any individual doctor, hospital, county, or family.

Some of the information available by individual doctor or hospital is:

Admissions by type,
Length of stay by diagnosis,
Cost per case,
Services and medicines by case,

Also, comparison of admissions, length of stay, and cost by case for a county, a doctor, or a hospital with State or other county averages.

For management in enrolled groups, this information is available on their group experience. Since utilization directly affects the dues paid in part or completely by the employer, this experience report can be valuable to him in helping to study use and investigate suspected abuse.



DATA PROCESSING DEPARTMENT, currently processing about 32,000 Physicians' Service Reports a month. Approximately 1,500 checks a week are issued to doctors.

BLUE SHIELD 1963 REPORT

Membership in Kentucky as of December 31, 1963, stood at 833,028 as compared to 789,634 for 1962—a net gain of 5.49%.

Payments in Kentucky by classification in 1963 were:

TYPE OF COVERAGE	NO. SERVICES	PAID TO DOCTORS
Surgical — In Hospital	68,966	$4,169,959
Home or Office	36,447	502,529
Medical — In Hospital (Cases Days 317,181)	48,682	1,621,404
Obstetrical	15,959	942,070
Anesthesia	49,484	834,646
X-ray	33,577	446,058
Diagnostic Exam.	4,246	36,202
Other	39	638
TOTAL	257,400	$8,553,506

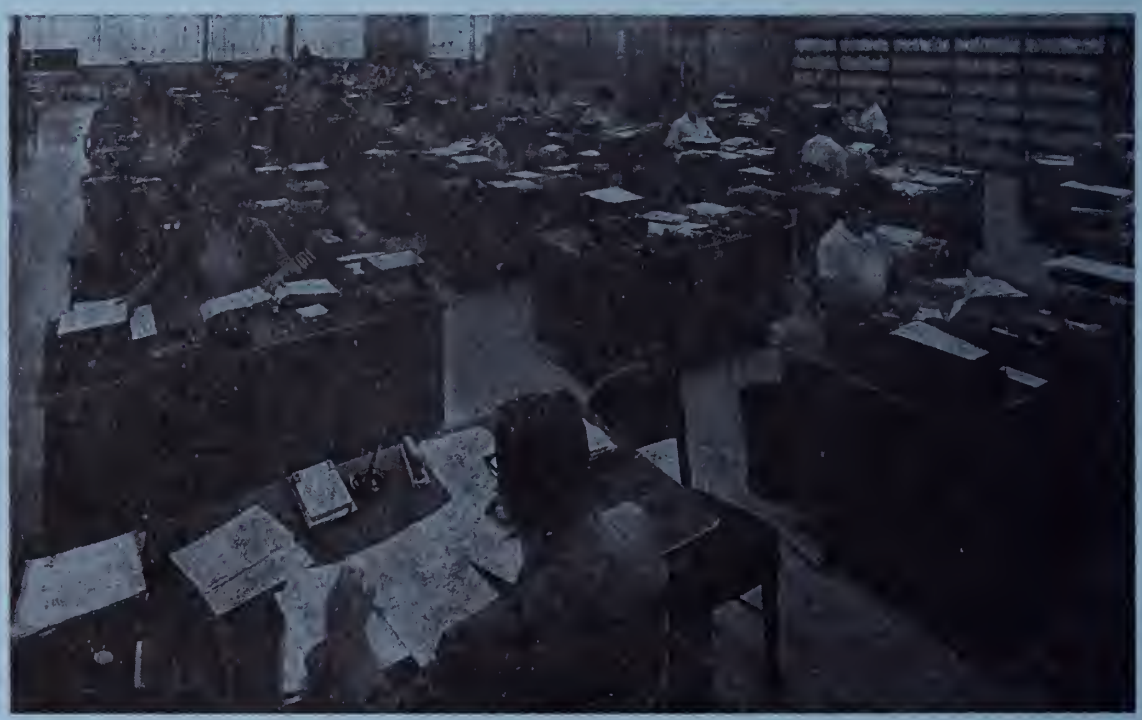
KENTUCKY BLUE SHIELD in 1963 PAID $8,553,506 to DOCTORS FOR 257,000 SERVICES TO BLUE SHIELD MEMBERS.

BLUE SHIELD GROWTH: A CITY A MONTH

Take the combined populations of the 125 largest cities in the United States (over 50 million people). Every month, add the number of people who live in Knoxville or Peoria or Canton (over 100,000). That gives you an indication of how many people are Blue Shield members and how fast membership is growing.

Membership rolls nationally are increasing by over 100,000 people a month.

Blue Shield now has over 53 million members.



BLUE SHIELD CLAIMS DEPARTMENT—There are 31 employees in the Blue Shield Claims Department. All Physicians' Service Reports are processed here and in Data Processing. Six of the Claims personnel are assigned primarily to inquiries and correspondence.

RATING OF GROUPS

Blue Shield groups up to the present have been community rated. Community rating means that dues are based on the combined experience of all Blue Shield members in the State of Kentucky.

However, with the approval of the Kentucky Insurance Department, Blue Shield is in the process of semi-community-merit rating groups. Groups for rating purposes are now divided into 3 classes:

Class 1—groups of less than 50 contracts.

Class 2—groups from 50 to 399 contracts.

Class 3—groups from 400 or more.

Rates are based on the cost of care plus overhead operations and required reserves. All group rates contain a community factor (per cent of dues) that is used to allow retirees, members who leave groups, and dependents of deceased members, to continue membership on a direct basis.

SAVE ON POSTAGE COSTS

Postage costs are higher now than they used to be. Reduce mailing expenses. When sending report forms to Blue Shield, three can be put in an envelope for one 5c stamp, if there are no additional papers—i.e. letters, operative reports, etc. Here are the mailing cost figures by weight:

No. of Report Forms	Postage
1 - 3	5¢
4 - 6	10¢
7 -10	15¢

HEALTH INSURANCE COUNCIL REPORTS

More than 145 million Americans—77% of the civilian population—had some form of health insurance at the end of 1963, the Health Insurance Council said June 29 in reporting on its 18th annual survey of the extent of voluntary health insurance coverage in the U. S. The survey is based on reports by insurance companies, government agencies, Blue Cross, Blue Shield and Medical Society plans.

The council said both the number of persons covered, and the amount of benefits paid by health insurance, reached new highs last year. Coverage increased by 3.9 million people during 1963 to reach a total of 145,329,000.

Benefit payments by all health insuring organizations to help cover the cost of *hospital, surgical and medical care* amounted in 1963 to nearly $6.9 billion, up $694 million over 1962. In addition, persons with *loss-of-income* policies received $936 million in benefits from insurance companies to replace income lost through disability. Thus, a *grand total* of $7,801,000,000 in health insurance benefits were distributed during 1963, up 10.2% over 1962.

BREAKDOWN BY TYPE OF COVERAGE AND INSURING ORGANIZATION

Hospital expense insurance was provided by insurance companies to 88,127,000 persons; by Blue Cross, Blue Shield and similar groups to 61,659,000 and by other health care plans to 7,221,000. After deducting persons protected by more than one type of organization, the council reported that 145,329,000 persons had hospital protection, a 2.8% increase over the 141,437,000 persons so covered at the end of 1962.

Surgical expense protection by insurance companies covered 84,958,000 persons; by Blue Cross,

Blue Shield and similar groups 52,474000, and by others 8,562,000. Allowing for duplication, 134,908,000 persons had surgical benefits, a 2.8% boost over the 131,185,000 persons of 1962.

Regular medical expense accounted for 49,708,000 persons through insurance company programs; 49,302,000 through Blue Cross, Blue Shield and similar groups; and 8,647,000 through other plans.

Major medical expense insurance coverage through insurance company programs increased 9.8%, from 38,250,000 to 42,010,000 persons.

DR. BLAKE VOICES BLUE SHIELD STAND ON "MEDICARE" BEFORE HOUSE COMMITTEE

Dr. Blake, Chairman of NABSP's Board of Directors, in testifying before the House Ways and Means Committee on January 23, said: "Rather than setting up an inadequate program for everyone who has attained a certain age—regardless of his need for it—we urge that Congress build upon the solid foundations of legislative enactment represented by the Kerr-Mills Program, and of voluntary initiative represented by Blue Shield and its companion hospital plan, Blue Cross. We urge that Congress take advantage of the knowledge and experience of the voluntary prepayment plans to strengthen the Medical Aid to the Aged Program. By doing so, we submit that Congress would discharge its public responsibility to the aged and it would also greatly contribute to the ultimate success of America's voluntary prepayment plans in serving the medical needs of the entire community."

REPORT CITES TAX ADVANTAGES AVAILABLE FOR HEALTH CARE INSURANCE

An article in a recent issue of *The J. K. Lasser Tax Report* states that . . . "an increasing number of children supporting parents are realizing the economic and tax advantages from advance funding to meet medical expenses if the parent becomes sick."

If the child meets the support test, that is, if he provides more than 50 percent of a parent's support, he is entitled to the following tax benefits if he pays the parent's health insurance premiums:

1) Full deduction for the premium. Unlike his own medical expense, his deduction is not limited to an amount in excess of three percent of his income. 2) Avoidance of high medical costs he otherwise would face in a year that the parent is seriously ill. Health insurance recovery substantially reduces his out-of-pocket costs. 3) Deduction for excess of a parent's medical expenses over insurance recovery.

FARM BUREAU

Blue Shield, the official surgical-medical plan of the Kentucky Farm Bureau Federation now has 63,433 members in the state.

Through May 31, 1964, Blue Shield has paid $4,084,711.36 to doctors for care of Farm Bureau Members.

BALANCE SHEET ··

YEAR 1963

ASSETS

Cash and Bank Deposits	$ 978,839
Subscription Income Receivable	352,071
Investments	3,853,632
All Other Assets	55,745
	$5,240,287

LIABILITIES

Claims Outstanding	1,371,061
Unearned Subscription Income	962,841
All Other Liabilities	37,695
Reserves Contingency	2,868,690
	$5,240,287

Blue Shield Plans are required to maintain three months of their average surgical-medical costs and administrative expense in reserve. Kentucky has 3.52 months; this represents $3.44 per member reserve.

Kentucky Blue Shield's operating expense per member per month was 10.6 cents while the national average was 15.2 cents. Kentucky ranked 12th among the 75 Blue Shield Plans in low overhead operation.

BLUE SHIELD IS UNIQUE BECAUSE:

1. Members who retire or leave the group may continue protection on a direct basis with accumulated benefits.
2. Eligible dependents of deceased subscribers may continue protection on a direct basis with accumulated benefits.
3. Blue Shield has never cancelled membership because of age or health.
4. Children 19, or marrying before 19, may continue protection in their own name.
5. Greater benefits because of efficiency and economy of operation.
6. Payments for services are made direct to doctors.
7. Blue Shield trustees serve without pay in the community interest.
8. Membership may be transferred from one group to another and from one state to another.
9. Medical decisions are made by medical doctors.

ORGANIZATION SECTION

Record Participation Expected In Diabetes Detection Drive

All members of the Kentucky Medical Association are urged by Robert S. Tillett, M.D., Louisville, chairman of the KSMA Diabetes Committee, to participate in the 1964 Diabetes Detection Drive November 15-21. This 14th annual drive is being sponsored again this year by the KSMA in cooperation with the American Diabetes Association.

It is anticipated that a record number of counties will participate in the program this year. Doctor Tillett stated that chairmen of county Diabetes Committees who have not ordered their supply of free Clinistix, should submit their order through the Kentucky State Medical Association, 3532 Janet Avenue, Louisville, Kentucky 40205.

All Kentucky physicians are asked to take part in the program and check urine samples free during the week of the drive. County chairmen are requested to submit complete reports following the drive to the KMA Headquarters Office.

New records were made during the 1963 Drive when 96,333 free tests were made and 182 proved cases were reported. More than 2,000 previous unknown diabetics have been found since the first drive was held in 1951.

AMA's 18th Clinical Convention Begins November 28 in Miami

The American Medical Association's 18th Annual Clinical Convention, to be held November 28-December 2 at Miami Beach, will offer physicians an excellent program of postgraduate medical education featuring sessions touching on nearly every phase of medicine, according to Donovan F. Ward, M.D., Dubuque, Iowa, AMA president.

Session devoted to obstetrics, vascular occlusive diseases, pulmonary diseases, and many others will highlight the program. A principal speaker among those scheduled for a series of eight lectures on vascular disease will be J. Alex Haller, Jr., M.D., formerly assistant professor of surgery and chief of the section on pediatric surgery at the University of Louisville. Doctor Haller is now associate professor of surgery at John Hopkins University.

The Sixth National Conference on the Medical Aspects of Sports will also be held on Sunday. November 29, in conjunction with the AMA meeting.

According to Doctor Ward, "Much effort is currently being exerted to provide better educational opportunities for practicing physicians. Yet, learning obviously remains an individual matter which rests on the personal initiative of each physician". The AMA executive urged that every physician who can possibly do so take advantage of the educational opportunity represented by the AMA clinical meeting.

12th Ky. Rural Health Conference Theme is "Health Careers"

"Health Careers" will be the theme of the 12th annual Kentucky Rural Health Conference which is scheduled for October 22 at the University of Kentucky Medical Center, Lexington, according to John Koon, Louisville, chairman of the Kentucky Rural Health Council.

The Council, which was founded in 1951 by KSMA and now has 25 member organizations, sponsors the conference. Greetings will be extended to those attending by Delmas M. Clardy, M.D., Hopkinsville, KSMA president. Purposes of the conference will be outlined by Robert Johnson, University of Kentucky Medical Center, program chairman.

The session will get underway at 9:30. Other speakers are Samuel Evans, Kentucky community employment program supervisor, who will focus on the employment and manpower situation in the State; and William R. Willard, M.D., vice president for the Medical Center, University of Kentucky, who will talk on employment needs in the health field.

Following the talks by Mr. Evans and Dean Willard, there will be a panel discussion featuring guidance counselors, a county school superintendent, and representatives of the State Health Department.

The afternoon will be devoetd to discussion groups made up of representatives of various agencies interested in health careers. They will discuss their own efforts and the overall needs of the State. The Rural Health Council will meet that night to review opinions discussed at the conference.

Annual Meeting To Be Reported

Because the Annual Meeting this year was held after the deadline for the October issue of The Journal, it was not possible to include reports of the meeting. The November issue will carry full coverage of general aspects of the meeting. The December issue, will, as always, include a digest of the proceedings of the House of Delegates meetings.



KSMA's booth at the State Fair this year centered on Safety and Protection of Life. Pictured above are the KSMA exhibits which formed a part of the Health-O-Drama booth for 1964.

KSMA Health-O-Drama Exhibit At Fair Features Protection

KSMA participated for the third straight year in the Health-O-Drama Exhibit at the 1964 Kentucky State Fair September 11-19. In the same number of years, Health-O-Drama has been an outstanding attraction at the Fair telling the story of Kentucky's vital health services.

Health-O-Drama, designed to present to Kentuckians some of the protective health measures now being used, is also directed toward educating the public in awareness of health. Health-O-Drama was first organized by the Kentucky Council on Allied Medical Services in 1962.

KSMA's 20-foot booth housed two exhibits on Safety and the Protection of Life. One exhibit urged the use of seat belts and the second exhibit demonstrated the life-saving uses of the Universal Emergency Medical Identification Symbol. The symbol was approved by the American Medical Association in June, 1963 and by the World Medical Association earlier this year.

Top Medical Lecturers Featured On Norton Seminar Dec. 17

Samuel T. Harbison, M.D., Pittsburgh, and William C. Sheldon, M.D., Cleveland, both nationally-known as outstanding lecturers and medical authorities, will be the guest speakers at the Seventh Annual Norton Memorial Seminar in Louisville December 17, according to Robert Lich, Jr., M.D., Louisville, program chairman.

The Seminar, co-sponsored again this year by the Kentucky Academy of Gencral Practice, will have as its theme, "An Evaluation of Recent Trends in Therapeutic and Diagnostic Medicine and Surgery".

Doctor Harbison, who is professor of surgery and chairman of the department of surgery at the University of Pittsburgh School of Medicine, will present two talks during the day-long program. They are "Routinism, Iatrogenetics and Surgical Care", and "An Evaluation of Recent Surgical Thinking".

Doctor Harbison is "one of the outstanding general surgeons in the United States, and has contributed much to general surgery and its progress", Doctor Lich said.

Doctor Sheldon, of the department of pediatric cardiology and the cardiac laboratory at the Cleveland Clinic, will present two motion pictures entitled "The Cine Cardioangiography of Acquired Valve Disease", and "Cine Coronary Arteriography".

Doctor Lich mentioned that cardiac evaluation by the method of movie photography was originated at the Cleveland Clinic, and said, "Doctor Sheldon's work is probably our first opportunity to provide a therapeutic and prognostic evaluation of heart disease."

Primarily directed toward the physicians of Kentucky and Southern Indiana, the Seminar is open to all physicians who care to attend. No registration fee will be charged, and lunch will be provided by the hospital.

A full program of the meeting will be presented in a subsequent issue of *The Journal.*



LOMOTIL®

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

- lowers motility promptly
- relieves spasm promptly
- stops diarrhea promptly

Lomotil fulfills the first order of treatment in most patients with diarrhea — prompt symptomatic control.

Pending discovery of the cause, early cessation of diarrhea is almost always urgently indicated. Prompt symptomatic control averts distress, dehydration and, frequently, severe exhaustion.

Both experimental and clinical evidence indicates that Lomotil exerts such control efficiently, safely and with maximal promptness.

dosage:

The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE

Research in the Service of Medicine

Dr. Welch, 1964 AMA President,, Dies During Wyoming Meeting

Norman A. Welch, M.D., 62, recently installed president of the American Medical Association, died September 2 of a cerebral hemorrhage suffered at Jackson, Wyoming, where he had gone to address a meeting of the Wyoming State Medical Society.



Doctor Welch

Doctor Welch, a Bostonian, had taken office as AMA president during the June meeting of the AMA in San Francisco. A long-time opponent of socialized medicine, he had a wide acquaintance in Kentucky and had spoken before medical organizations here.

He was former speaker of the AMA House of Delegates and a graduate of Harvard Medical School.

Doctor Welch was succeeded in office by President-Elect Donovan F. Ward, M.D., Dubuque, Iowa, a former AMA vice-president. A new president-elect will be chosen during the AMA's Fall Clinical Meeting in Miami November 28-December 2.

SMA 58th Annual Meeting Set Nov. 16-19 in Memphis

Special symposia on a variety of diseases, color television presentations, and 22 individual programs by specialty sections will be among the features of the 58th Annual Meeting of the Southern Medical Association scheduled for November 16-19 at Memphis.

Other activities planned for the 1964 meeting include alumni reunions for a number of medical colleges represented in SMA, and the annual president's luncheon on November 17 and president's night dinner dance November 18. A special program has been arranged for the ladies.

Information on the complete program of this important meeting and applications for reservations may be obtained by writing The Southern Medical Association, 2601 Highland Ave., Birmingham 5, Ala.

Communities Plan Observance Of Oct. 18-24 Health Week

The second annual observance of Community Health Week will be held October 18-24. Medical societies and allied health groups across the nation will join in planning and presenting community activities appropriate to the occasion.

The primary goal of Community Health Week is to focus public attention, at the community level, on the health progress and medical advances that have been made and to stress the responsibility of each citizen in planning future needs of medical and health services.

Members of the KSMA Council on Communications and Public Service encourage county medical societies to invite both public and private health agencies to participate in Community Health Week and to be your partners in developing the most appropriate local program for observance. This week affords an opportunity to demonstrate the cooperation between the medical profession and community health agencies.

Some of the most successful Community Health Week campaigns have featured science fairs, health fairs, hospital tours, health forums, and school health programs—all appealing subjects of wide local interest.

Proctologic Group To Meet

The Ohio Valley Proctologic Society will meet October 23 and 24 at the French Lick Sheraton Hotel, according to Henry B. Asman, M.D., Louisville, program chairman.

Several Kentucky members are on the program, which will be presented to an expected attendance of 50. Doctor Asman said any KSMA member wishing to attend would be welcomed.

Medical School News

U. of L. Announces Medical Faculty Changes

The Board of Trustees of the University of Louisville at their September 16 meeting, announced a number of faculty appointments and changes within the School of Medicine.

The Board announced the following new staff appointments: Guillermo Espejo, M.D., instructor in medicine; Alan A. Schwartz, Ph.D., instructor in pharmacology; Joseph B. Brill, M.D., clinical instructor in psychiatry; Everett T. Mays, M.D., instructor in surgery; Robert E. Amis, M.D., instructor in surgery; and Hoyt D. Gardner, M.D., associate clinical professor of community health (he is also clinical instructor in surgery).

Other appointments are: Paul B. Johnston, M.D., associate professor of microbiology; Billy Andrews, M.D., associate professor in microbiology (he is also an assistant professor of pediatrics.)

Promotions were given to: William H. Gillespie, M.D., and S. Randolph Scheen, M.D.,—both promoted to senior clinical instructor of medicine; Gerald Landau, M.D., to assistant professor of surgery; and Salwan J. Baban, M.D., to assistant professor of surgery.

Samuel H. Cheng, M.D., has been named chief of the section of gastroenterology, and Leonard Leight, M.D., chief of the section of cardiology.



ACHROCIDIN®

TETRACYCLINE HCI-ANTIHISTAMINE-ANALGESIC COMPOUND

Each Tablet contains:

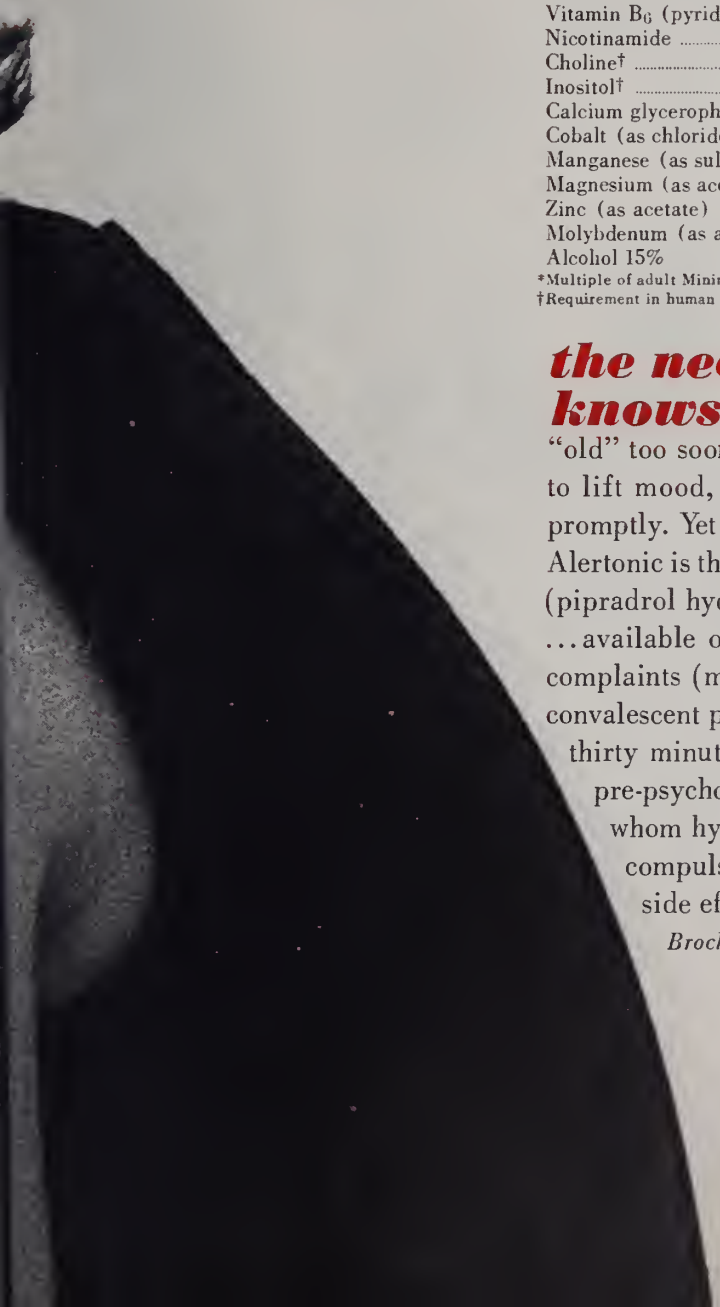
ACHROMYCIN® Tetracycline HCl	125 mg.	Caffeine	30 mg.
Acetophenetidin (Phenacetin)	120 mg.	Salicylamide	150 mg.
		Chlorothen Citrate	25 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms. Tooth discoloration may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Reduce dosage in impaired renal function. Average Adult Dosage: 2 Tablets four times daily.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

too young to be so tired...





revive interest... restore activity promptly with

AlerTonic®

Three tablespoonfuls (45 cc.) contain:		
Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ... available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio / Weston, Ontario

AMA Sets Education Program On Available Health Care

The American Medical Association recently announced a national educational program during the observance of Community Health Week October 18-24, to inform the public on the broad range of health care now available to the elderly who cannot pay for it.

Kentucky physicians will be asked to lead the effort in the state by person-to-person explanations to their patients of existing programs of health care for the elderly citizens who cannot afford it.

Paid advertising will be a part of the program, used in cooperation with state and county medical organizations. F. J. L. Blasingame, M.D., executive vice-president of the AMA, said, "This is an educational program. It is not intended to influence congressional action on pending legislation, since the program is not scheduled to begin until October. By then Congress will have disposed of medicare legislation and adjourned."

A thirty-minute television program has been scheduled for October 18 from 5:00 to 5:30 p.m. EDT, on the CBS television network. Other news media will be employed for advertising.

Dr. Deuschle Represents AMA

Kurt W. Deuschle, M.D., professor and chairman of the department of community medicine at the University of Kentucky College of Medicine, was official representative of the American Medical Association to the Annual Meeting of the International Union Against Tuberculosis held in Paris, France, September 10-11.

SMJAB Elects New Executive

John L. Murphy, M.D., former advertising director of the American Medical Association, has been named to head sales and promotions activities of the State Medical Journal Advertising Bureau, Inc., Frank B. Ramsey, M.D., Indianapolis, SMJAB president, announced recently.

Mr. Murphy succeeds Alfred J. Jackson, who retired this summer. The new sales and promotions officer will be located in New York City.

Blood Bank Session Set for Dec.

The American Medical Association will sponsor a Conference on Blood and Blood Banking December 11-12 at the Drake Hotel in Chicago. The objective of the conference is to "motivate the medical profession to evaluate and implement blood banking requirements and to participate generally in local blood banking affairs," said Gunnar Gundersen, M.D., La Crosse, Wis., chairman of the AMA Committee on Blood.

Pathologists Visit Russia

Twenty-six members of the College of American Pathologists left New York August 26 for a ten-day tour of Russian pathology laboratories. The group was invited to meet with Russian Pathologists on a doctor-to-doctor basis as guests of the Soviet Ministry of Health.

Anesthesiology Course Set

The department of Anesthesiology at the University of Louisville will hold its 4th Annual Postgraduate Course in Anesthesiology on Wednesday, October 28, 1964 in the Surgical Conference Room at Louisville General Hospital.

Leonard W. Fabian, M.D., professor and chairman of the department of Anesthesiology at the University of Mississippi College of Medicine will be a member of the guest faculty. The program will be devoted to discussion of Muscle Relaxants and Clinical Toxicology. The program is directed toward the part-time practitioner of anesthesiology and has been approved for six hours Category I credit by the American Academy of General Practice. Advance registration is not required.

Dept. of Mental Health Reports

A record number of patients were treated in and released from Kentucky's four State mental hospitals during the year July 1, 1963 to June 30, 1964, according to the Kentucky Department of Mental Health. There were 7.2% more patients admitted to the Department's hospitals last year than in the previous year, 7% more were placed out of the hospitals, 7.9% more patients were discharged from the hospitals. The resident population of the four hospitals on June 30 was 5,229—a 4.1% decrease from the preceding year.

WANTED:
MALE PSYCHIATRIST

OPENING FOR A BOARD ELIGIBLE OR BOARD CERTIFIED PSYCHIATRIST TO JOIN A WELL-ESTABLISHED GROUP.

IDEAL WORK CONDITIONS IN A 145-BED ACTIVE TREATMENT HOSPITAL SERVING SEVERAL SOUTHEASTERN STATES.

PROFESSIONAL FREEDOM. GOOD LIVING CONDITIONS.

Starting Salary - $20,000-25,000.

FOR FULL PARTICULARS
WRITE BOX 5 THIS JOURNAL.







TAKE 5

...and find that a TB screening test has never been quite so easy

SWAB THE ARM— UNCAP A TINE TEST— PRESS—DISCARD THAT'S ALL THERE IS TO IT.

Comparable to the Mantoux in accuracy and sensitivity, the TUBERCULIN, TINE TEST is now available in plastic-capped units uniquely suited to general practice needs. They are so simple to use that you can test every patient with ease. Since it requires no refrigeration, the new package of five Tine Test units can stand on any convenient table in your examining rooms, ready for routine use. Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis.

available as the new individually-capped unit, boxes of 5, or in cartons of 25

TUBERCULIN, TINE TEST
(Rosenthal) Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle
7699-4

IMPORTANT NOTICE FOR DOCTORS WITH PATIENTS IN CINCINNATI HOSPITALS

SOUTHERN ARMS 'Toothbrush Apartments'



DESIGNED EXPRESSLY FOR HOSPITAL OUT-PATIENTS AND MEMBERS OF FAMILIES WHO MUST BE NEAR A HOSPITALIZED PATIENT

Completely furnished and equipped — near all major hospitals

- SHUTTLE SERVICE TO ALL HOSPITALS
- ONE BEDROOM AND EFFICIENCIES
- AIR-CONDITIONED, FREE TV
- LINEN, EATING AND COOKING UTENSILS FURNISHED
- MAID SERVICE, NURSE ON CALL, RESIDENT MANAGER
- DAILY, WEEKLY, MONTHLY RATES

Tell your patients or their relatives to see these modern, convenient, new apartments, just minutes from all major hospitals.

621-6420

SOUTHERN ARMS 2058 Auburn Ave., at Southern Avenue

CINCINNATI, OHIO

News Items

Coy E. Ball, M.D., has started general practice in Owensboro in association with **Jack C. Collings, M.D.** Following his graduation from the University of Louisville School of Medicine in 1961, he interned at Louisville General Hospital. Prior to moving to Owensboro, Doctor Ball practiced in Glasgow.

Robert A. Hall, M.D., has returned to his home town of Paintsville to practice in the office of **Paul B. Hall, M.D.** Doctor Robert Hall, a surgeon, received his M.D. from the University of Louisville in 1946 and maintained a general practice at Paintsville until 1960 when he become a surgical resident at Baylor Medical Center, Houston, Tex.

F. Calvin Bigler, M.D., has become associated with **Herbert Hudnut, M.D.**, and **Warren Proudfoot, M.D.**, at the St. Claire Medical Center, Morehead. Doctor Bigler's practice will be limited to general surgery. He is a 1957 graduate of the Yale University Medical School and interned at Bassett Hospital. Cooperstown, N.Y., where he was also a resident.

Charles D. Scarborough, M.D., a general practitioner, has become associated with Houston-McDevitt Clinic at Murray, it was recently announced. A 1961 graduate of Washington University Medical School, Doctor Scarborough interned at Riverside Hospital, Columbus, O.

Carl T. Evans, M.D., is now associated with The Lexington Clinic, Lexington, where he will limit his practice to obstetrics and gynecology. He received his M.D. from Jefferson Medical College and interned at Misericordia Hospital in Philadelphia before completing his residency at Temple University Hospital.

Martha Gilliland, M.D., has become staff physician at the Red Cross Regional Blood Center in Louisville, it was recently announced. Doctor Gilliland, a 1941 graduate of the University of Louisville School of Medicine, interned at Kentucky Baptist Hospital, Louisville, and was a resident in obstetrics and gynecology at Mayo Clinic. From 1946 until her return to Louisville, Doctor Gilliland has been serving as a medical missionary in Ogbomosho, Nigeria.

E. A. Jones, M.D., a pediatrician, is now practicing in association with the Lexington Clinic. A graduate of Vanderbilt University School of Medicine in 1959, Doctor Jones interned at Childrens' Hospital Medical Center, Oklahoma City, before returning to Nashville to complete his residency requirements at Vanderbilt Hospital.

Stuart E. Harlowe, M.D., has opened an office in Louisville, where his practice will be limited to urology. Doctor Harlowe, who received his M.D. from the University of Louisville in 1959, interned at Louisville General Hospital and recently completed his residency at Vanderbilt University Hospital.

The case of diaper rash



solved by NEW UNDERCOVER AGENT

BAKER'S **CREME**

DIAPER-SIL™



CONTAINS : panthenol, benzalkonium chloride, dimethylpolysiloxane, in a water-miscible cream base.

eliminates ammonia-splitting bacteria. The bactericidal component, benzalkonium chloride, has a proven record of effectiveness. It acts rapidly against a wide range of organisms implicated in diaper-rash — including Brevibacterium ammoniagenes and Alcaligenes faecalis.

soothing, healing, protective. DIAPER-SIL also provides panthenol in a special base containing silicone . . . helps to soothe inflamed skin, protect from external irritants and gently promote healing.

TO HELP PREVENT AND TREAT DIAPER RASH, CHAFING AND SIMILAR CONDITIONS

BAKER LABORATORIES, INC. Cleveland, Ohio 44115

Subsidiary of U.S. Vitamin & Pharmaceutical Corp.

RECOGNIZE THIS PATIENT?



"The arthritis doesn't get any better... I can't get out. I never see anybody. It's awful to be sick... I was always so active."

When you recognize depression and anxiety related to an organic condition
—*add 'Deprol' to your therapy*

Typical organic conditions in which 'Deprol' helps control related depression and anxiety:

cardiovascular disorders ■ arthritis ■ cancer ■ menopause ■ alcoholism ■ obesity ■ asthma, hay fever and related allergies ■ chronic infectious diseases ■ dermatoses ■ G.I. disorders, and many other debilitating or life-threatening illnesses

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' relaxes physical tensions, restores normal sleep and revives interest in food.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is compatible with drugs used to treat co-existing organic conditions.
5. 'Deprol' is relatively nontoxic and free of side effects.

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 tablet t.i.d. or q.i.d. May be increased gradually, as needed, to 6 tablets daily. With establishment of relief, may be gradually reduced to maintenance levels. **Supplied:** Light-pink, scored tablets Bottles of 50.

WALLACE LABORATORIES / *Cranbury, N. J.*

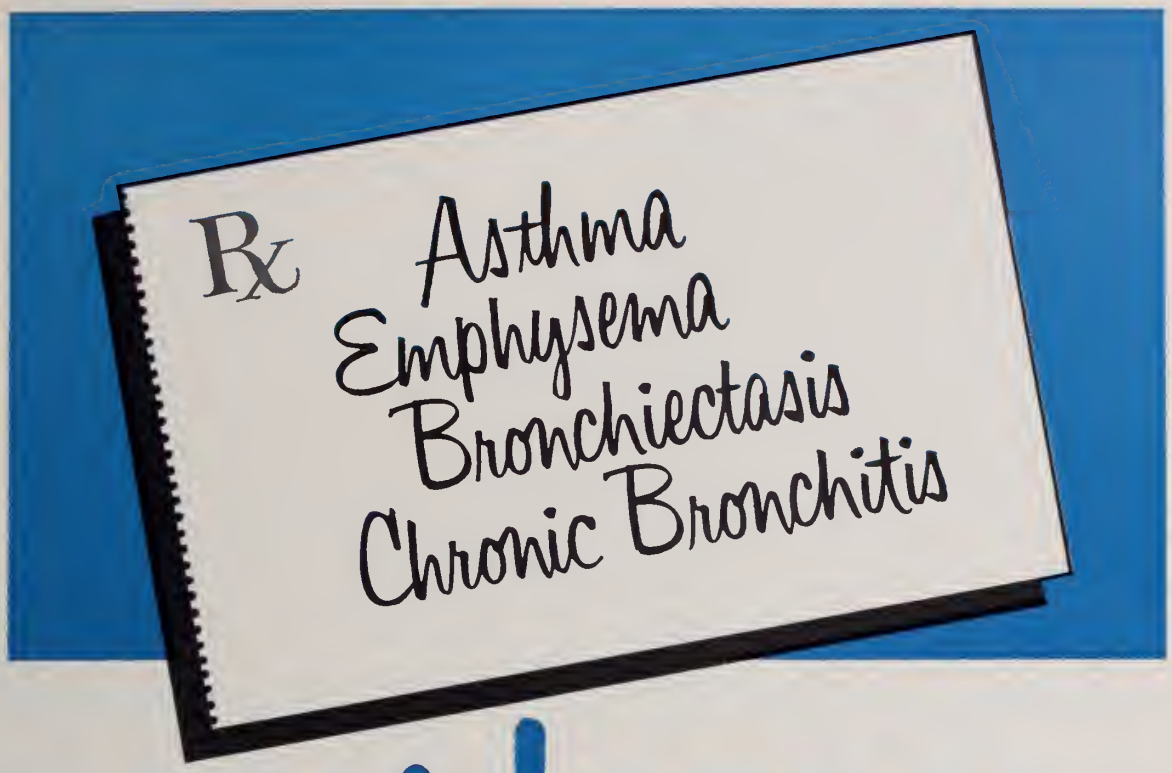
CO-801



one of the fundamental drugs in medicine

Smith Kline & French Laboratories

SK&F



mudrane®

The Bronchodilator with the intermediate dose of KI

The fast-disintegrating, uncoated tablet gives relief to the asthmatic in 15 minutes. The ephedrine-phenobarbital balance eliminates nervousness. It relaxes broncho-constriction, liquefies mucus-plugging and is buffered for tolerance.

Each tablet contains Aminophylline 130 mg., Ephedrine HCl 16 mg., Phenobarbital 22 mg. (Warning: may be habit-forming), Potassium Iodide 195 mg. Dosage: One tablet, 3 or 4 times a day. Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, and very long use may cause goiter. Iodide contraindications: tuberculosis, pregnancy. Issued in 100's, 1000's.

Also available as

mudrane® GG

Formula is identical to Mudrane except that Glyceryl Guaiacolate 100 mg. replaces the Potassium Iodide as the mucolytic expectorant. Issued in 100's and 1000's.

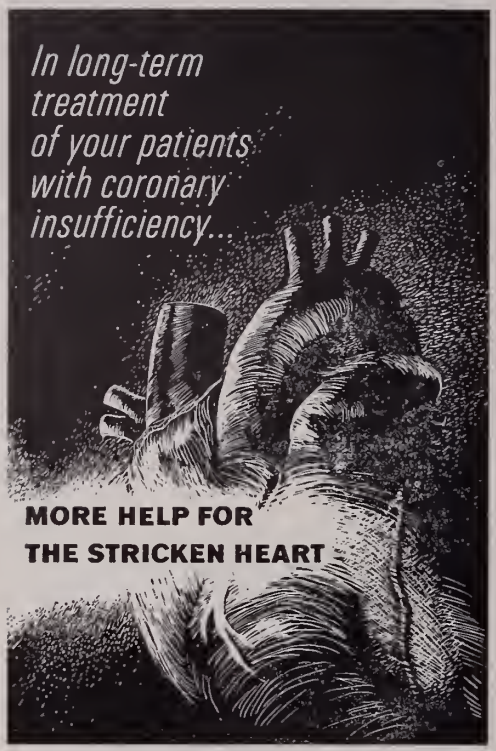
and

mudrane® GG ELIXIR

The formula of four teaspoonfuls Elixir equals one Mudrane GG tablet. Dosage 6 to 12 years: One to two teaspoonfuls 3 or 4 times a day. Under 6 years, adjust dosage according to age. Issued in pints and half gallons.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856



■ PETN (pentaerythritol tetranitrate) to increase oxygen supply

■ plus meprobamate to decrease anxiety and tension

Unlike phenobarbital, meprobamate is *not* cumulative and does *not* cause depression.

Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. **Precautions:** Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. **Contraindications:** Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* **Dosage:** 1 to 2 tablets, *before meals* and at bedtime. Individualization required. **Supplied:** Bottles of 50 tablets.

CML-1055

MILTRATE®

meprobamate 200 mg. + pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

News Items

William Carpenter, M.D., has been appointed new director of the School Health and Accident Prevention Program at the Kentucky State Department of Health. He is also health officer for Powell, Clark, Wolfe and Menifee Counties.

J. W. Urton, M.D., a psychiatrist, is the new clinical director of Frankfort State Hospital and School, Frankfort. Doctor Urton, who graduated in 1960 from the University of Louisville School of Medicine, interned at SS. Mary and Elizabeth Hospital in Louisville and completed his residency at that hospital.

Herman D. Pocock, Jr., M.D., has been appointed as new medical director at General Electric's Appliance Park in Louisville, according to a recent announcement. Doctor Pocock, a 1944 graduate of the University of Cincinnati School of Medicine, interned at Cleveland City Hospital and completed his residency in internal medicine at Crile Hospital in Cleveland. He was in private practice in Cleveland from 1948 to 1954.

Paul A. Keeney, M.D., has become new director of medical education at SS. Mary and Elizabeth Hospital in Louisville, it was announced recently. Doctor Keeney, who graduated in 1931 from the University of Pittsburgh School of Medicine, interned and completed his residency in internal medicine at St. Francis Hospital, Pittsburgh. He received his master's degree in Public health from Johns Hopkins University in 1940. Doctor Keeney was formerly chief of clinical services for the Miners' Memorial Hospital Association.

John C. Bates, M.D., Elizabethtown, has announced the discontinuance of his office practice. Doctor Bates, a native of Iowa, graduated in 1952 from the University of Louisville School of Medicine.

William T. Daniel, M.D., Corbin, has joined the staff of Southeastern Baptist Hospital in that city, where he will limit his practice to radiology. He is a 1954 graduate of the University of Louisville School of Medicine. Doctor Daniel was in general practice in Louisville before his residency training.

* * * *

Applications are now being received for Wyeth Pediatric Residency Fellowships that will begin on July 1, 1965. Sponsored by the Wyeth Fund for Postgraduate Medical Education, each fellowship provides $4,800 over a period of two years. Requests for application forms and information should be directed to Philip S. Barba, M.D., University of Pennsylvania School of Medicine, Philadelphia, Pa., 19104. All applications must be received by December 1, 1964.



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective **GERIATRIC** antiarthritic with

REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention... the enteric coating assures gastric tolerance... and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate-SF

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe
PABALATE-SODIUM FREE



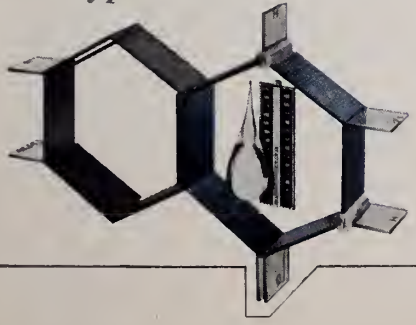
Just turned hypertensive

A 15 mm. Hg drop in diastolic pressure would also suit her very well

For suitably gradual, physiologic hypotensive treatment



HYDROMOX®
QUINETHAZONE·TABLETS
antihypertensive diuretic



HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle

#373-4

Health Facilities Meeting Set

The First National Conference on Areawide Health Facilities Planning will be held November 28-29 in Bal Harbour, Fla., in conjunction with the 18th Annual Clinical Convention of the American Medical Association, according to Charles C. Edwards, M.D. acting director of the AMA department of Hospitals and Medical Facilities.

The meeting is designed for the purpose of gaining insight and understanding into the growing need for health facilities planning through an exchange of current experiences and new developments between physicians, medical societies, and the community, Doctor Edwards said. Requests for information should be sent to the AMA Department of Hospitals and Medical Facilities, 535 North Dearborn St., Chicago, Ill. 60610.

Governor Appoints Dr. Gaines

Frank M. Gaines, M.D., Louisville psychiatrist, was appointed recently by Governor Edward T. Breathitt to head a committee to "recruit, screen, and interview candidates" for the office of mental health commissioner for Kentucky.

The new commissioner will replace Harold McPheeters, M.D., who resigned in July. Also on the committee are William R. Willard, M.D., dean of the U. of K. College of Medicine, and Louisville psychiatrists John P. Bell, M.D., and Arthur R. Kasey, M.D.

OVER 80 YEARS'
SPECIALIZED EXPERIENCE
IN THE RESTORATIVE
TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

News Items

Don C. Pearl, M.D., a general surgeon, recently joined the University of Kentucky Medical Center. Doctor Pearl graduated from Harvard Medical School and took his internship and residency training at Massachusetts General Hospital.

Robert B. Cloar, M.D., has started in general practice in Pineville in association with **C. B. Stacy, M.D., and B. B. Mills, M.D.** A 1963 graduate of Tulane University Medical School, New Orleans, he plans to open another office in Middlesboro this fall. He interned at McLeod Infirmary, Florence, S. C.

William R. Yates, M.D., is now in general practice in Bloomfield. A graduate of the University of Louisville School of Medicine in 1961, he interned at SS. Mary and Elizabeth Hospital, Louisville. He served two years as a captain in the Air Force.

Paul M. Weeks, M.D., a plastic surgeon, has joined the department of surgery, University of Kentucky Medical Center. Doctor Weeks graduated from the University of North Carolina School of Medicine in 1958 and interned at North Carolina Memorial Hospital.

David C. Kay, M.D., has joined the staff of the U.S. Public Health Service Hospital in Lexington as a psychiatrist. A native of Michigan, Doctor Kay graduated from the University of Illinois Medical School in 1958. He interned at Presbyterian-St. Luke's in Chicago and took his residency training at the Illinois State Psychiatric Institute, Chicago.

Richard F. Hench, M.D., Lexington, has become associated with **John E. Myers, Jr., M.D.**, in that city, where he will limit his practice to internal medicine. He is a 1956 graduate of the Temple University School of Medicine and completed both his internship and residency at Walter Reed Army Hospital.

Tom E. Hall, M.D., has begun general practice at Louisville, it was recently announced. Doctor Hall, who graduated in 1956 from the University of Louisville School of Medicine, interned at the U.S. Navy Hospital in Jacksonville, Fla. He was previously in practice in Madison, Ind., and at Pleasure Ridge Park, Ky.

Robert T. Johnson, M.D., has opened an office at Beaver Dam, where he will practice general medicine in association with **James M. Lee, M.D.** Doctor Johnson received his M.D. from the University of Louisville School of Medicine in 1963 and interned at St. Elizabeth Hospital in Dayton, O.

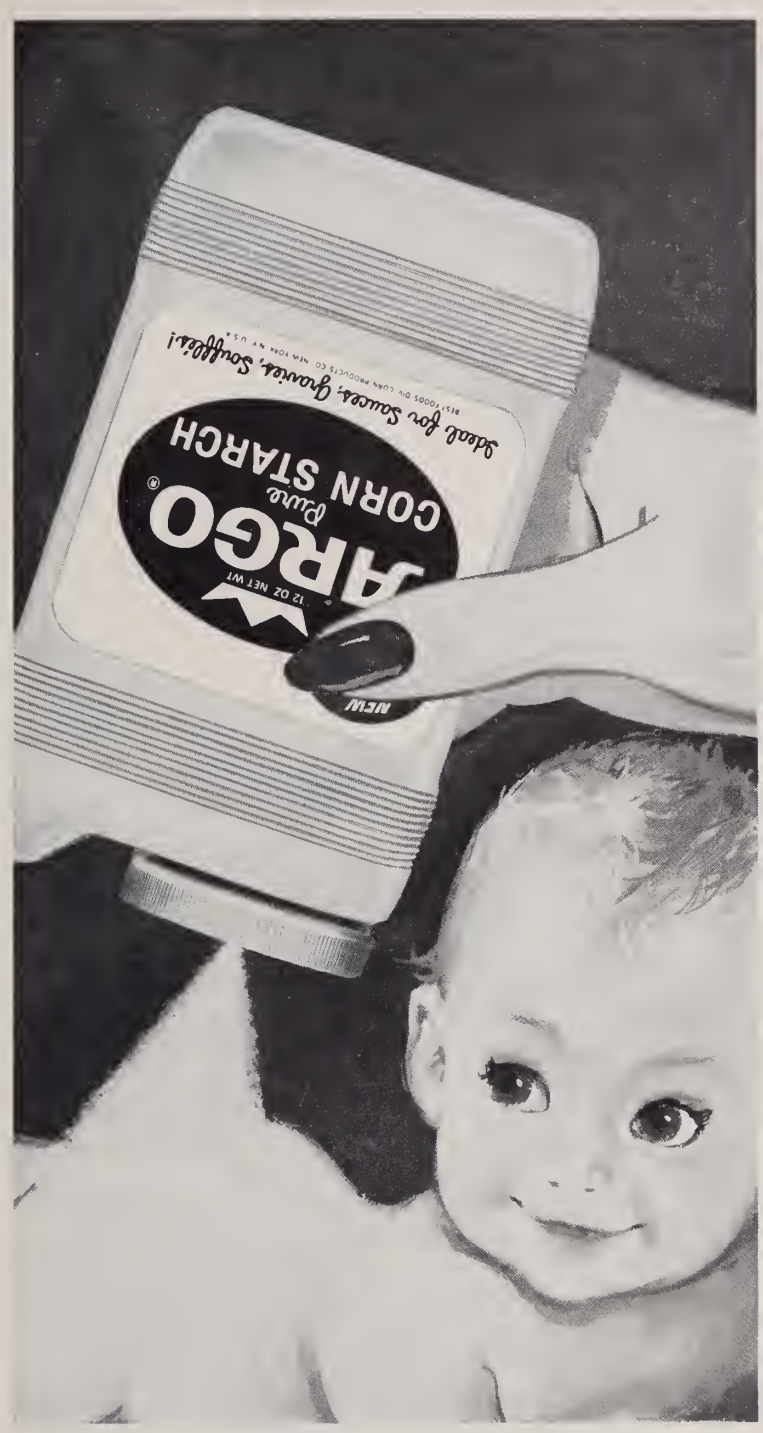
Daniel W. Klein, M.D., has started practice at Herrington Lake, Burgin, where he will have a general practice. Doctor Klein, who previously practiced in Minnesota, graduated in 1944 from the University of Minnesota School of Medicine and interned at St. Mary's Hospital, Detroit. He completed a residency in psychiatry while serving in the U.S. Public Health Service.

NOW IN HANDY-PACK

Argo Pure Corn Starch the Ideal Baby Powder

ARGO HANDY-PACK It's the ideal plastic dispenser for dusting powder on babies. By squeezing the sides, the new Handy-Pack puffs out the exact amount of Argo required. Easy to use, the Argo Handy-Pack is reusable, too. Just remove cap and refill from the yellow and blue Argo packages to have a permanent, economical dusting powder dispenser.

ARGO CORN STARCH Argo Corn Starch is safer than ordinary baby powder because it contains no abrasives. Argo Corn Starch dries up moisture . . . soothes irritating rash and chafed skin. And Argo leaves a velvet-smooth film on skin to guard against further irritation. Argo in the new plastic Handy-Pack is pure corn starch in its most convenient form.





Send for a free Argo Handy-Pack filled with pure Argo Corn Starch

BEST FOODS
P. O. BOX 6282, CHICAGO, ILL. 60677

Name_____

Address_____

City_____ State_____ Zone_____

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

Pulmonary Program Set for U.K.

"The Clinical Application of Pulmonary Function" will be the topic of a postgraduate education program scheduled to be held at the University of Kentucky Medical Center all day on November 11 and 12. A registration fee of $20 will be charged. Registration will be limited to 25 physicians. For further information, write to the University of Kentucky Medical Center.

IN KENTUCKY

OCTOBER

8-10	Pediatric Course, "A New Look at Old Diseases", University of Kentucky Medical Center, Lexington
26-27	American Association for Automotive Medicine, Stouffer's Inn, Louisville, Kentucky
28	Postgraduate Course in Anesthesiology, General Hospital, Louisville

SURROUNDING STATES

OCTOBER

8-10	American College of Physicians, Hotel Biltmore, Los Angeles, Calif.
10-14	American Society of Anesthesiologists, Bal Harbour, Florida
15-21	Association of American Medical Colleges, Denver Hilton Hotel, Denver, Colorado
17-20	College of American Pathologists, Americana Hotel, Bal Harbour, Fla.
18-21	American College of Gastroenterology, Roosevelt Hotel, New York, N.Y.
18-23	American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Ill.
23-24	American Heart Association, Chalfonte-Haddon Hall, Atlantic City, New Jersey
24	American Academy of Pediatrics, New York Hilton, New York, N.Y.
28-29	"Blood Bank Symposium", the Cleveland Clinic Educational Foundation, Cleveland, Ohio
28-30	American Cancer Society, Biltmore Hotel, New York, New York

NOVEMBER

7-8	National Conference on Disaster Medical Care, LaSalle Hotel, Chicago
9-12	Interstate Postgraduate Medical Association of North America, Pittsburgh, Pennsylvania
16-19	Southern Medical Association, Memphis, Tennessee
20-21	American Psychiatric Association, Bellevue Stratford Hotel, Philadelphia, Pennsylvania
28-29	American College of Chest Physicians, Interim Meeting, Miami Beach, Florida
29	National Conference on Medical Aspects of Sports, AMA, Miami Beach, Fla.
29-Dec. 2	AMA Clinical Meeting, Miami Beach, Florida

DECEMBER

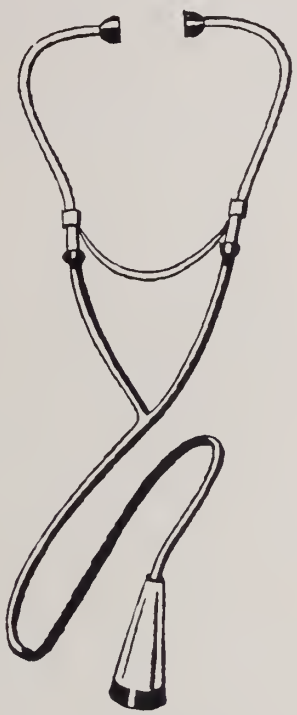
8	Southern Surgical Association, Boca Raton Hotel, Boca Raton, Florida

SUBMIT DATES OF PG MEETINGS

From now to the end of the year, many medical organizations are selecting dates for next year's meetings. Some are already selecting topics and speakers and planning programs.

The Continuing Medical Education Office of KSMA would like to urge these societies and organizations to notify this office of the dates and topics, so they can be added to the "Continuing Educational Opportunities" page in The Journal. In this manner we hope to avoid conflicts in dates and to inform a large audience of these up-coming meetings.

You are urged to submit this information to the KSMA Continuing Medical Education Office, 3532 Janet Avenue, Louisville, Ky. 40205



RECOMMEND

BLUE SHIELD . . . THE UNIQUE MEDICAL-SURGICAL PREPAYMENT PLAN . . . ORGANIZED BY DOCTORS FOR PEOPLE . . . TO HELP THEM VOLUNTARILY BUDGET IN ADVANCE FOR CARE

Blue Shield and its companion Hospital Protection Plan, Blue Cross, have never cancelled membership because of age, health, retirement, or an incurable physical condition.

BLUE SHIELD KENTUCKY PHYSICIANS MUTUAL, INC.

BLUE CROSS BLUE CROSS HOSPITAL PLAN, INC.

3101 BARDSTOWN ROAD — LOUISVILLE, KY.
PHONE 452-1511



THE INSURANCE PAGE



WE congratulate Blue Shield on its 25th anniversary.

A short 25 years ago, many Americans hit by serious illness faced medical bills which mortgaged their earnings for years to come. A method was desperately needed to insure Americans against the high cost of unexpected medical care.

Insurance companies were approached by the medical profession at that time and asked to provide health insurance protection. Doctors were told that underwriting such protection was unfeasible.

The medical profession, recognizing its responsibility to the community, had to devise some way to ease the financial and emotional burden of medical expenses upon those who became ill. In 1939, the California Medical Association took the lead by formulating the first Blue Shield type plan which enabled members to prepay their medical expenses on a community-wide basis.

In the early years, the insurance companies' warning that health insurance underwriting was unfeasible seemed all too realistic. Too many dollars were paid out in relation to income received. By trial and error, physician-trustees and administrators of early Blue Shield plans were able to put plans on the sound actuarial basis that exists today.

The phenomenal quarter century growth of Blue Shield to 83 autonomous plans, with over 53 million members receiving better than a billion dollars in benefits in 1963, proves that Americans, given the opportunity, prefer to voluntarily prepay their medical-surgical expenses.

Blue Shield, on its 25th anniversary, with only the slightest pause to look back with pride on its 25-year success story, girds for the challenges ahead. The challenges are great.

Striking advances in medical science are continually pushing the cost of medical care to record highs. Blue Shield coverage seeks to encompass the latest medical innovations without pricing Blue Shield out of the range of the low income groups and other disadvantaged segments of the population.

President Johnson's administration, in continuing to seek passage of the King-Anderson bill (Medicare) through a Senate amendment this session, is attempting to discredit the health care prepayment plans by ignoring the progress made by Blue Shield and other voluntary health care plans in providing health care protection.

Thus, two of the major challenges which lie ahead for Blue Shield are those of continuing to provide an equitable, actuarially sound income-benefit relationship, while showing that government instrusion into the health care field is unnecessary.

Actually, these are problems Blue Shield has faced for the past 25 years. Though the problems are greatly intensified now, Blue Shield's past record gives every indication that they will be successfully met in the years to come.

W. VINSON PIERCE, M.D.



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective
GERIATRIC
antiarthritic
with

REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention... the enteric coating assures gastric tolerance... and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate-SF

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe
PABALATE-SODIUM FREE

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

A SYMPOSIUM ON INFECTIOUS DISEASES

November 11, 12, 13, 1964

To focus on selected problems in diagnosis, treatment and prevention of infections which may affect all ages within a family:

Enteric Viruses and Gram-negative Bacilli

Respiratory Viruses, Streptococci and Staphylococci

Histoplasma capsulatum and Atypical Mycobacteria

By the faculty of **Vanderbilt University School of Medicine** assisted by the following distinguished visitors:

Dr. Dorothy Horstmann — Yale University

Dr. Warren E. Wheeler — University of Kentucky College of Medicine

Dr. George Jackson — University of Illinois College of Medicine

Dr. Floyd Denny — University of North Carolina School of Medicine

For Information write:

Director of Continuing Education
B-4211 Vanderbilt University School of Medicine
Nashville, Tennessee 37203

Registration Fee $60.00



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lossiter, Representative
203 Porkside Building, 4140 Shelbyville Road, Louisville 7
Mailing Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884

MT. HOLLY
NURSING HOME

A Nursing Home with Hospital Standards



- *24 Hour Personal, Medical and Nursing Care supplemented by Closed Circuit Television.*
- *Balanced and Therapeutic Diets.*
- *Facilities for Orthopedic, Geriatic and Medical Patients.*
- *Leisure time activities.*

MT. HOLLY NURSING HOME

OFF BROWNSBORO ROAD 897 - 1646

In Memoriam

HARVEY C. HARDEGREE, JR., M.D.
Louisville, Ky.
1920-1964

Harvey C. Hardegree, Jr., M.D., 44, who had practiced general surgery in Louisville for the past nine years, died September 8 of cancer. Doctor Hardegree, a 1950 graduate of the University of Oklahoma School of Medicine, was a native of Atlanta. Among his survivors is his father, H. C. Hardegree, Sr., M.D., former administrator of the Louisville Veteran's Administration Hospital.

PERRY CLINE SANDERS, M.D.
Danville, Ky.
1881-1964

Perry C. Sanders, M.D., 82, who retired as Boyle County Health officer in 1958, died September 10 at Danville following a short illness. Doctor Sanders, a 1910 graduate of the old Medical Department of the University of Louisville, served from 1931 to 1947 as part-time health officer for Boyle County while maintaining his private practice. In 1947 he then became full-time health officer.

VINCENT CORRAO, M.D.
Munfordville, Ky.
1896 - 1964

Vincent Corrao, M.D., 68, a general practitioner in Hart County for 38 years, died suddenly in Philadelphia while visiting in that city. Doctor Corrao, a 1921 graduate of the Royal Academy of Medicine in Naples, Italy, interned at St. Agnes Hospital in Philadelphia and began practice in 1926, moving to Hart County shortly afterward.

Pathologists Visit Russia

FENTON THOMAS ADAMS, M.D.
Covington, Ky.
1882 - 1964

Fenton Thomas Adams, M.D., 82, Covington, died August 8 after a long illness. Doctor Adams, who graduated in 1906 from the Medical Department of the University of Louisville, retired in 1958 after 52 years of practice in Covington. He was a native of Vanceburg.

LEONARD E. STINSON, M.D.
Benton, Ky.
1879 - 1964

Leonard E. Stinson, M.D., 85, Benton, a 1904 graduate of the Loiusville Medical College, died September 2. Doctor Stinson still maintained his general practice at the Sharpe community where he had begun practice in 1908. Prior to that time he had been located in Graves County.

J. F. HARRELL, M.D.
(formerly) Bardwell, Ky.
1879 - 1964

J. F. Harrell, M.D., 85, died August 7 at his home in Little Rock, Ark. Doctor Harrell, former health officer for Carlisle County, left Kentucky in 1956. He was a 1906 graduate of Gate City Medical College in Dallas. Doctor Harrell was a native Texan.

WILLIAM KENNETH KANNARD, M.D.
Louisville, Ky.
1902-1964

William Kenneth Kannard, M.D., 61, retired Louisville general practitioner, died September 16 of head injuries suffered in a fall. Doctor Kannard, who graduated in 1928 from the University of Louisville School of Medicine, had not practiced for several years.

MAURICE BELL, M.D.
Eminence, Ky.
1871-1964

Maurice Bell, M.D., 93, retired Henry County general practitioner, died August 26 at a New Castle hospital. Doctor Bell, who retired in 1960, graduated from the Kentucky School of Medicine in 1893 and had practiced in Eminence for 51 years.

MURFREESBORO - VACANCIES: STAFF PHYSICIANS for 1275 bed neuropsychiatric hospital, including 350 general medical and geriatric. Modern facilities for diagnosis and treatment of mental illness. Salary $11,150 to $18,405 depending on qualifications; fringe benefits; cost of moving to Murfreesboro will be paid by Veterans Administration; visit here for evaluation can be arranged at our expense. Excellent educational opportunities for students in this area. Contact Director, Veterans Administration Hospital, Murfreesboro, Tenn.



WHY DOES ONE ANTIBIOTIC GIVE UP TO 2 EXTRA DAYS' ACTIVITY?

Because it is more resistant to disintegration, has a lower renal clearance rate than earlier tetracyclines[1]...a favorable depot effect resulting from protein binding and greater mg. potency...all giving higher, sustained *in vivo* activity which continues long after the last dose.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections — respiratory, urinary tract and others — in the young and aged — the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.
Side Effects typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules*, 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Kunin, C. M.; Dornbush, A. C., and Finland, M.: Distribution and Excretion of Four Tetracycline Analogues in Normal Young Men. *J. Clin. Invest.* 38:1950 (Nov.) 1959.

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
7517-3

Lederle



What every bride should know about U.S. Savings Bonds

Mother may have forgotten to mention it, but there are some important things you should know about U.S. Savings Bonds when you get married.

1. Your Savings Bonds should be reissued in your married name. They'll continue to earn interest as they are, but reissuing them now will help avoid problems when you want to cash them in some day.

2. If you want to be named co-owner or beneficiary on your husband's Bonds, these should be reissued, too.

Your bank will help you with this, no charge.

Of course, now that you have so much to save for, you'll want to keep on buying U.S. Savings Bonds. As well as providing money for many of the things you'll need, they help protect your freedom to live happily ever after.



Value at maturity—$50. Cost—$37.50.

Help yourself while you help your country

BUY U.S. SAVINGS BONDS

This advertising is donated by The Advertising Council and this magazine.

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses

NEW MEN'S SHOP



. . . in our NEW SOUTHERN

OPTICAL BUILDING, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

Guild Opticians

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th

IN THE BOOKS

CURRENT DIAGNOSIS AND TREATMENT, 1964: by Henry Brainerd, M.D., Sheldon Margen, M.D., Milton J. Chatton, M.D., and associate authors; published by Lange Medical Publication, Los Altos, Calif., 1964; 872 pages; Price, $9.50.

The preface states that "This book is intended to serve the practicing physician as a useful desk reference on the most widely accepted technics currently available for diagnosis and treatment. It is not intended to be used as a textbook of medicine."

Essentially all areas of medicine are covered except surgery and its sub-specialties. Each disease entity is included in a systematic way, including essentials of diagnosis, general considerations, clinical findings, differential diagnosis, complications, treatment and prognosis.

Hence, despite the disclaimer of the preface, it is perfectly obvious that this is, indeed, a textbook of medicine. It differs from the standard texts in having half as many pages, being paper bound and costing about half as much.

This book must therefore be judged vis a vis standard textbooks of medicine such as Cecil and Loeb or Harrison. In general, the authors of the sections in the standard textbooks have made more contributions to their chosen fields than have the section authors in this text. Furthermore, they give the physician reader considerably more information on which to form his *own* opinion on what course he should follow.

On the positive side, this book offers the physician the reassurance of the one, two, three approach (often numbered as such). Its chief value, however, lies in presenting actual dosage schedules of drugs. Standard textbooks often omit this because of the rapid changes in the field. Realistically, however, the only really up to date information on drugs is that in the *Physicians desk Reference* and the package inserts, tempered by *The Medical Letter*. Furthermore, these same authors publish a handbook on treatment for less than half the price.

It is clear that the practicing physician must obtain new editions of a standard textbook of medicine as they appear. I do not believe that *Current Diagnosis and Treatment* can replace this. If it is so used, I would consider this undesirable. Better and more current information on therapy can be obtained from other sources.

KINGSLEY M. STEVENS, M. D.

SURGERY IN WORLD WAR II: ACTIVITIES OF SURGICAL CONSULTANTS; Vol. II, Medical Department, U. S. Army. Published by the Office of the Surgeon General, 1964.

Activities of Surgical Consultants, Volume II, is one of some twenty-six volumes either planned or published as part of the official medical history of World War II. This particular book deals with the activities of surgical consultants in Europe and in the Pacific and Asia.

The activities of these men, most of whom were civilians and physicians first and soldiers second, is presented in great detail. The chapters are written by the consultants themselves, or prepared from diaries or official records, and they represent an important record of the difficulties of war time medical practice.

History is often presented in a manner so dull that it's important lessons are lost. Fortunately this is not the case here. The personality of the authors comes through in every chapter, and the facts of history are seasoned with personal observations and anecdotes, and decorated with many interesting photographs. Presented in such a setting, the valuable lessons learned through the bitter experiences of World War II are more readily passed on. The contribution of this volume to medical history is futher enhanced by the inclusion of an excellent index.

In some respects, it is regrettable that almost twenty years have elapsed between the end of World War II and the publication of this volume. For example, the Chief Consultant in Surgery, Elliot C. Cutler died before the book was written. Fortunately, for this work, he left an extensive diary that was used in preparation of the chapter on the activities of the Chief Surgical Consultant. And as some of the other authors point out, the lapse of twenty years may have dimmed the exact recollection of events. On the other hand, the intervening of years lends a certain perspective to historical writing.

The Medical Department of the United States Army is to be commended on the publication of this volume, for it is a valuable contribution to medical history.

DONALD M. THOMAS, M.D.

test yourself

How much does the average American spend each year on these?

TOBACCO	ALCOHOL	R_X DRUGS
		
☐ $19	☐ $36	☐ $141
☐ $63	☐ $84	☐ $76
☐ $42	☐ $57	☐ $13

Score yourself 100% if you checked the bottom figure in each column. Yes, the U.S. Department of Commerce reports that 1962 per capita expenditure was $42 for tobacco, $57 for alcohol, only $13 for prescription drugs. That's about 25 cents per week per person for drugs that helped them stay well, get well, or possibly helped save their lives. Can you think of a bigger bargain?

Your patients might like to take this test, too. May we send you 25 copies for your waiting room?

Pharmaceutical Manufacturers Association — 1411 K Street, N.W., Washington, D.C. 20005

This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE #7-62. A 32 year old gravida IV, para III, was referred to the attending obstetrician for cesarean section. Past obstetrical history revealed the following. On August 27, 1954 she was delivered vaginally of a full term stillborn infant weighing 8 pounds 4 ounces. The second pregnancy terminated on December 20, 1958 after a vaginal delivery. This infant expired during the first 24 hours of life of unknown cause. The third pregnancy terminated on June 23, 1959 following an eight-hour labor, a stillborn 7½ pound infant was delivered.

She was seen initially for the present pregnancy on the 4th of October, 1961, and prenatal care was continued. Last menstrual period had occurred on the 22nd of July, 1961, giving an E.D.C. of 4-29-62. Physical examination was normal with the exception of obesity of 207 pounds. She was RH positive and a VDRL was non reactive on 11-4-62.

Date	10-4	11-1	11-28	12-29	1-26	2-9	2-23	3-9	3-16	3-23
Wt.	207	210	211	216	217	218	219	224½	222	222
BP	150/10	130/80	140/80	140/70	136/80	140/80	140/80	140/80		

Edema Slight—urine albumin negative

The patient was admitted to the hospital on 3-27-62 and delivered of a 3 pound 15 ounce living infant by classical cesarean section under spinal anesthesia the following day. The post-operative course was described as uncomplicated. On April 1, 1962 while going to the bathoom she was heard to groan. Upon opening the door she was found lying on the floor unable to speak and in shock. Oxygen was administered, no pulse or blood pressure was obtained, respiration ceased. Artificial respiration was given in addition to intramuscular and intravenous coramime. She expired at 7:45 a.m.

At autopsy a cylindrical mass stradling the bifurcation of the pulmonary artery was found. It extended into the right main branches of the pulmonary artery for a greater distance than it did into the left pulmonary artery.

The immediate cause of death was massive pulmonary embolus source underermined. Gross and histo-pathologic examinations of the other organs was within normal limits.

Comment

The committee classified this a direct obstetrical death with preventable factors on the part of the physician. The classical cesarean section was performed in the hopes of obtaining a living infant that would survive. However, this baby was very small weighing only 3 pounds 15 ounces. The question was raised as to what measures were taken to estimate fetal size. It is felt that classical cesarean section should only be used in cases of placenta previa or in cases of prematurity when a lower uterine segment is not well developed. Surgical procedures pre-dispose to pulmonary embolism in that about 1% of surgical patients develop venous thrombosis which is fatal in approximately 0.2% of cases. Certain prophylactic measures have only sporadically partially diminished the incidence of venous thrombosis and embolic disease. Fatal pulmonary emboli such as the above case occur often without previous warning. In approximately 50% of the cases no previous signs or symptoms are present to give warning of this catastrophe.[1] The incidence of fatal pulmonary embolism following routine vaginal delivery is not this high and it was felt by the committee that serious thought must be undertaken before the operation of cesarean section is performed.

Reference

1. Kistner, R. W., and Smith, G. V. Surgery, Gynecology and Obstetrics, 98: 437-445, 1954.

News Items

Newton B. Griffin, M.D., will practice in association with **C. Joseph McGruder, M.D.** at Henderson. A 1957 graduate of Vanderbilt School of Medicine, Doctor Griffin was a surgical intern at Vanderbilt and completed his residency there. From 1963 to 1964 he held an advanced clinical fellowship in gynecology at Anderson Hospital, Houston, Tex. His practice will be limited to obstetrics and gynecology.

Fulton M. Greer, M.D., has become associated with **A. R. Morgan, M.D., Donald C. Haugh, M.D., W. B. Simpson, M.D., and C. F. Burnett, Jr., M.D.,** at Mayfield, where he will practice general medicine. A 1963 graduate of the University of Tennessee College of Medicine, Doctor Greer interned at John Gaston Hospital, Memphis.

Henry A. Jones, M.D., has started general practice at Flatwoods, it was recently announced. Doctor Jones, who graduated from the University of Louisville of Medicine in 1960, interned at St. Elizabeth Hospital in Dayton, O. He has recently completed three years of service as a Captain in the U.S. Air Force.

Horace A. Norrell, M.D., has become a full-time faculty member in the department of Surgery at the University of Kentucky Medical Center. Doctor Norrell, a neurosurgeon, graduated from Tulane University School of Medicine in 1958 and completed both his internship and residency at Charity Hospital of Louisiana in New Orleans.

Robert P. Simmons, M.D., has announced the opening of his office at Greensburg, where he will practice general medicine. A native of Greensburg, he graduated in 1963 from the University of Louisville School of Medicine and interned at Brooke Army Hospital.

H. W. Ford, M.D., has located in Benton where he will do general practice. Doctor Ford received his M.D. degree from the University of Louisville School of Medicine and interned at St. Louis County Hospital, St. Louis, Missouri.

Robert M. Conlon, M.D., is now practicing in association with The Lexington Clinic. He wil limit his practice to otorhinolaryngology. A 1957 graduate of Indiana University School of Medicine, Doctor Conlon interned and completed his residency at Charity Hospital, New Orleans.

Pertinent Paragraphs

The introduction of a new drug and indeed the continued use of some established drugs would be impossible without the use of experimental laboratory animals. Only when a drug has passed stringent initial tests on animals for toxicity, clinical safety and usefulness can it pass into the hands of the clinical investigator for use in man. These tests constitute a vital chain in the long process from the time a new drug is prepared until it finds its way into the hands of the physician for use in the alleviation of human disease.—Arthur Grollman, M.D., in *Southern Medical Bulletin,* Dec. 1963.

Millions of Americans are walking the streets today who —but for the new drug discoveries—would have died long ago from pneumonia, flu, tuberculosis, and countless other diseases which now can be cured with medicines. Of 94 important drugs discovered since 1945 and in use today 47 were discovered in U.S. drug industry laboratories or by scientists working under drug industry grants.—Senator Hugh Scott (R. Pa.) to Philadelphia Drug Exchange in *Congressional Record,* Feb. 19, 1964.

If the growth of the drug industry's medical research can be termed rapid, that of the Government can only be called phenomenal. For example, it would appear that the Federal Government's contributions to medical research were $3 million in 1941, $119 million in 1954 and, according to the National Science Foundation, over $900 million in 1963, or over 300 times what they were a little more than 20 years ago.—Austin Smith, M.D., President, Pharmaceutical Manufacturers Association, in letter to Honorable Carl Elliott, Chairman, House of Representatives' Select Committee on Government Research, December 20, 1963.

If better known drugs won't work, it is easier to see why the practitioner will turn to a new one. While Osler praised "masterly inactivity", this is not part of the American tradition. We are assertive men. To sit and wait for laboratory or x-ray results—to see the patient's symptoms wax with no offer to help—is repugnant to most of us. A doctor who depends on bromides to treat epilepsy would be considered behind the times, and most of us—however nostalgic we may get about the good old days—don't want to be prescribing Fowler's solution for chorea just because our grandfathers did.—Editorial in *Journal of the Medical Society of New Jersey,* 61:3 (Mar.) 1964.

As a result of widespread use of the anti-tuberculous drugs, the mortality from tuberculosis has decreased sharply, and the length of hospital stay and the relapse rate have also greatly decreased. Of all the people who have ever lived, more have died of tuberculosis than of any other disease. Our generation has been fortunate to have been given the tools with which this once dreaded disease may be eradicated. Let us not fail to us them wisely.—A. C. Cohen, M.D. in *Pennsylvania Medical Journal,* 67:2 (Feb.) 1964.

THE DERMATOSES THAT WERE STEROID-UNTREATABLE

Salt and water retention, edema, overstimulation o the appetite, excessive weight gain, mood swings— these were some of the problems that used to confron physicians when they wanted to prescribe steroids fo dermatoses. For patients already overweight, or with edema associated with cardiovascular disease, o those who were tense and anxious, steroid treatmen could aggravate their problems. But with the advent of ARISTOCORT® Triamcinolone, many of these patients became "steroid-treatable." The reason: Not only did *this* steroid provide gratifying symptomatic relief, but it did so *without* the penalty of overstimulation of the appetite, excessive weight gain, salt and water retention, edema, and undesirable euphoria. And these benefits have been confirmed for other patients with steroid-susceptible disorders, as well as those formerly untreatable.



Side Effects: Since it may, under some circumstances, produce many of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.
Contraindications: While the only absolute contraindications are tuberculosis, herpes simplex and chicken pox, there are some relative contraindications (peptic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

A single daily dose may provide effective control, is convenient for the patient, and can be employed in both initial and maintenance therapy.

MAXIMUM STEROID BENEFIT—MINIMUM STEROID PENALTY

Aristocort®

Triamcinolone

1 mg., 2 mg., 4 mg. or 16 mg. tablets

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

272-4



KENTUCKY STATE MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1964-1965

Officers

DELMAS M. CLARDY, Hopkinsville ..... President
EVERETT H. BAKER, Louisville ..... President-Elect
GEORGE P. ARCHER, Prestonsburg ..... Immediate Past President
ROBERT W. LYKINS, Louisville ..... Vice President (Central)
HAROLD B. BARTON, Corbin ..... Vice President (Eastern)
KENNETH M. EBLEN, Henderson ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, CORBIN ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
DOUGLAS E. SCOTT, Lexington ..... Chairman of the Board of Trustees
GABE A. PAYNE, JR., Hopkinsville ..... Vice Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

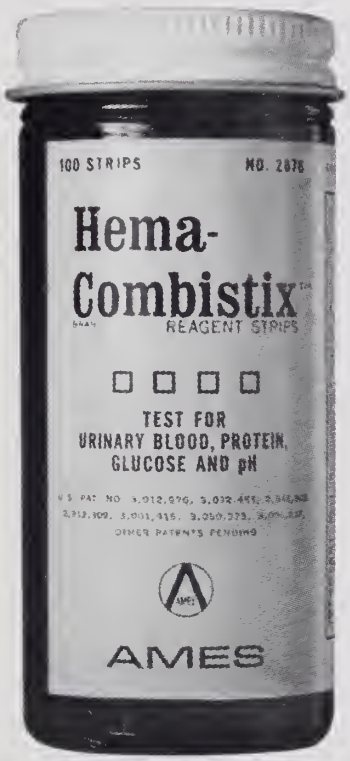
Trustees

First District ..... O. LEON HIGDON, 2515 Broadway, Paducah 1965
Second District ..... GERALD EDDS, Calhoun 1967
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville 1967
Eighth District ..... DON JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1967
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1967
Eleventh District ..... HUBERT C. JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... WALTER L. CAWOOD, Kings Daughters Hospital, Ashland 1967
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

Buyers Guide

JOURNAL OF THE KSMA BUYERS GUIDE FOR OCTOBER, 1964

Ames Company 82S
Baker Laboratories 797
Blue Cross Hospital Plan 809
Burroughs Wellcome 748
Coca Cola Company 812
Corn Products Company 807
The Keeley Institute 806
Lederle Laboratories 746-791-795-804-80S-81S-822-823
Eli Lilly & Company 752
Medical Protective Company 813
William S. Merrell Company 792-793
Mt. Holly Nursing Home 813
New Castle Sanitarium 812
Parke, Davis & Company 740
Pfizer Laboratories 747-749-7S0-7S1
Pharmaceutical Mfg. Co. 819
William A. Poythress & Company 801
A. H. Robins Company 811-803
Roche Laboratories 826
W. B. Saunders 741
G. D. Searle & Company 789
Smith Kline & French 800
Southern Arms Apartments 796
Southern Optical Company 812
Vanderbilt University 812
Veterans Administration 814
Wanted 794
Wallace Laboratories 74S-798-799-802
Winthrop Laboratories 743



WARNING: MAY BE HABIT-FORMING

Once you have used **HEMA-COMBISTIX,**™ dip-and-read test for urinary blood, protein, glucose, and pH, it may become a habit to test every patient's urine routinely with this simple, convenient reagent strip. Most of the answers will be "negatives," but an unexpected "positive" may alert you to serious pathology even before related symptoms appear. The test takes only 60 seconds. As basic as the stethoscope...**HEMA-COMBISTIX** is a *good* habit to form. ☐ Ames Company, Inc., Elkhart, Indiana. 68764

AMES

When psychic tension mounts

Valium® (diazepam)

useful in alleviating

- psychic tension mixed with depressive symptoms
- psychic tension in the common psychoneuroses
- psychic tension intensified by concomitant somatic disorders





How to prescribe Valium (diazepam)

Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue.

Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal.

Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in dealing with psychotic patients manifesting anxiety and should be avoided when there is reason to believe the patient is psychotic.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.*, convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

Valium (diazepam) is available as 5-mg and 2-mg tablets. For convenience and economy in prescribing, both strengths are supplied in bottles of 50.

Roche Laboratories endorses the principle of caution in the administration of any therapeutic agent to pregnant patients.

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, N. J. 07110

NOVEMBER 1964 • VOLUME 62 • NUMBER 11

THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



LIBRARY OF THE COLLEGE OF PHYSICIANS SEP 7 1965

In This Issue

Pheochromocytoma: Recent Experiences with Two Cases
B. B. Jackson, M.D., J. E. Bryan, M.D., and F. A. Olash, M.D. 853

Liver Biopsy: A 10 Year Survey
F. Norman Vickers, M.D., and David P. Price, B.A. 857

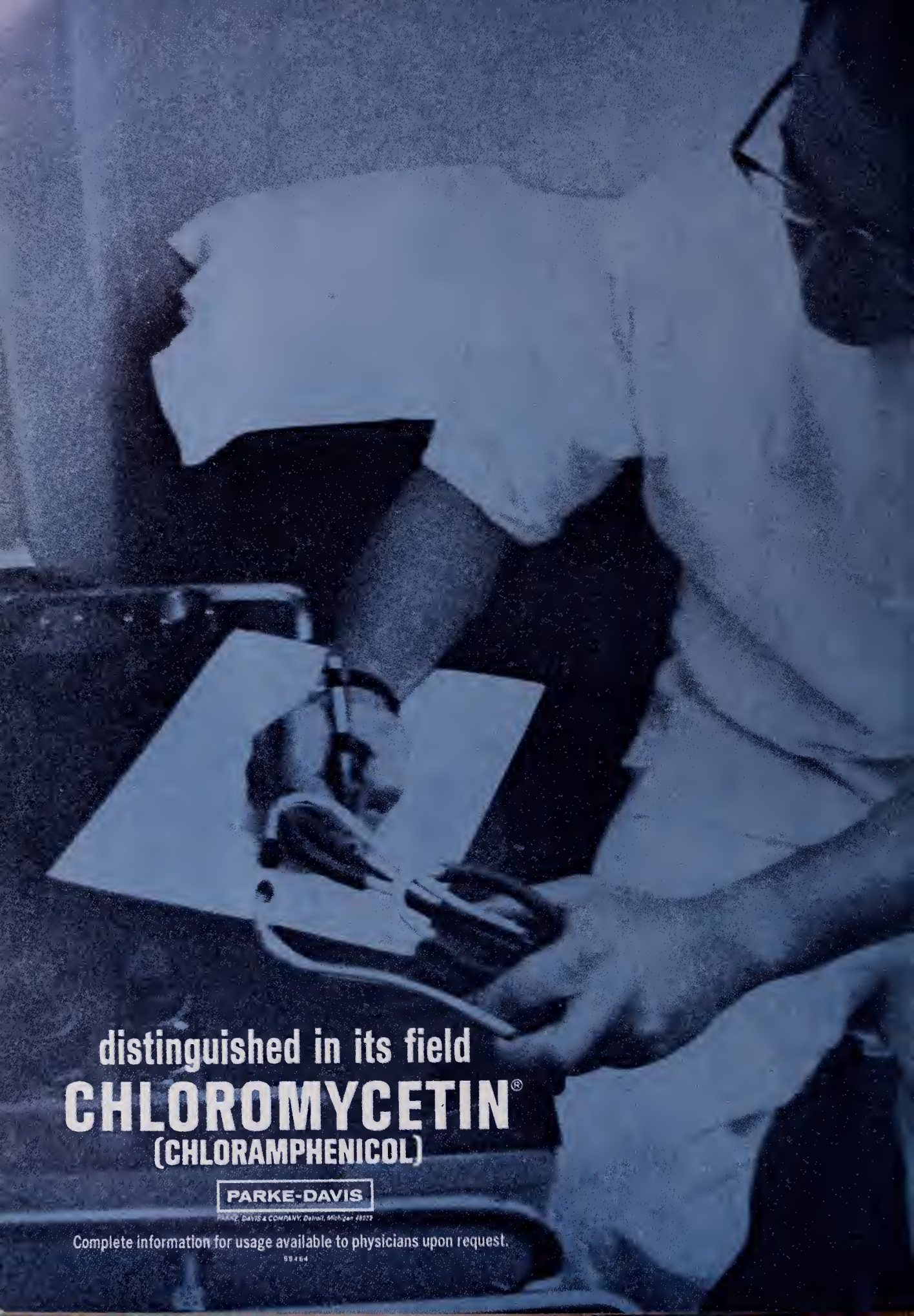
Management of the Occiput Posterior
Robert J. Griffin, M.D. 860

Preleukemia: An Unusual Case of Nine Years Duration
Will W. Ward, M.D. 862

Selective Gastric Vagotomy
Gordon L. Hyde, M.D. and David A. Hull, M.D 865

Role and Contributions of a State Mental Health Department to Community Mental Health
Dale H. Farabee, M.D. 868

Complete Contents on Page 830


distinguished in its field
CHLOROMYCETIN®
(CHLORAMPHENICOL)
PARKE-DAVIS
PARKE, DAVIS & COMPANY, Detroit, Michigan 48232
Complete information for usage available to physicians upon request.
99464



ACHROCIDIN®

TETRACYCLINE HCl-ANTIHISTAMINE-ANALGESIC COMPOUND

Each Tablet contains:

ACHROMYCIN® Tetracycline HCl	125 mg.
Acetophenetidin (Phenacetin)	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Each (5 cc.) Teaspoonful of Syrup (lemon-lime flavored) contains:

ACHROMYCIN® Tetracycline equivalent to Tetracycline HCl	125 mg.
Acetophenetidin (Phenacetin)	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben 4 mg.; Propylparaben	1 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms, tooth discoloration. The last named may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Average Adult Dosage: 2 Tablets or 2 Teaspoonfuls of Syrup four times daily. The total average daily dosage for children, determined by the tetracycline content, is 10 to 20 mg. per pound body weight, divided into four equal doses.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

7143-3

Lederle

VOLUME 62 • NOVEMBER 1964
Issued Monthly Under the Direction of the Board of Trustees

• EDITOR
Sam A. Overstreet, M.D.

• ASSOCIATE EDITOR
Walter S. Coe, M.D.

• MANAGING EDITOR
J. P. Sanford

• ASST. MANAGING EDITOR
Ann M. Huntsman

• DEPARTMENTAL EDITORS
Jack L. Chumley, M.D., Scientific
Eugene H. Conner, M.D., Book Reviews
Oscar J. Hayes, Case Discussions
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR
George F. Brockman, M.D., Chairman
Willett H. Rush, M.D.
Blaine Lewis, M.D.
Orson P. Smith, Jr., M.D.
Andrew M. Moore, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1967
Edword C. Groves, M.D.
Carl W. Kumpe, M.D.
Morvin A. Lucas, M.D.
Robert N. McLeod, Jr., M.D.
Henry W. Post, M.D.
Clinton R. Potts, M.D.
Oscar Thompson, M.D.
George I. Uhde, M.D.

Term Expires July 1, 1966
Harold L. Bushey, M.D.
Edword J. Fadell, M.D.
Merle W. Fowler, Jr., M.D.
Joseph L. Goldstein, M.D.
John D. Lovett, M.D.
George F. McAuliffe, M.D.
Rolph G. Thomas, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965
McHenry S. Brewer, M.D.
Lewis Dickinson, M.D.
Zygmunt Gierloch, M.D.
Douglas L. Gillim, M.D.
Arthur H. Keeney, M.D.
James B. Stith, M.D.
Chester B. Theiss, M.D.
Keorns R. Thompson, M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205
Subscription $8.00—single copy .80
Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

JOURNAL of the KENTUCKY MEDICAL ASSOCIATION

Contents

SCIENTIFIC ARTICLES

Pheochromocytoma: Recent Experiences with Two Cases
Benjamin B. Jackson, M.D., James E. Bryan, M.D., and F. Albert Olash, M.D. 853

Liver Biopsy: A 10 Year Survey at Louisville General Hospital
F. Norman Vickers, M.D. and David P. Price, B.A. 857

Management of the Occiput Posterior
Robert J. Griffin, M.D. 860

Preleukemia: An Unusual Case of Nine Years' Duration
Will W. Ward, M.D. 862

Selective Gastric Vagotomy
Gordon L. Hyde, M.D. and David A. Hull, M.D. 865

The Role and Contributions of a State Mental Health Department to Community Mental Health
Dale H. Farabee, M.D. 868

CASE DISCUSSION

Eclampsia: A Case Report
John L. Duhring, M.D. and Donald Edger, M.D. 871

SPECIAL ARTICLES

The Aims and Purposes of Medical Assistants
Bettye J. Fisher 874

Diabetes—An Old Enemy
Robert Hendon, M.D. 875

EDITORIALS

Everybody's Doin' It Now 877

Diabetes Week 879

ORGANIZATION SECTION

Dr. Baker Chosen by Delegates as KMA President-Elect 880
Drs. Pennington and Chatham to Lead Board of Trustees 880
KMA Members Planning to Attend AMA's Miami Beach Meeting 881
Mrs. Salisbury Chosen President-Elect of KMA Woman's Auxiliary 881
President's Luncheon Speaker Prescribes Dose of Laughter 882
Ky. Physicians Slated to Speak at SMA Meeting in Memphis 884
Drs. Simpson and Hall Honored by KMA at Annual Meeting 884
Kentuckians to Participate in AMA Mental Health Congress 885
Senators Bayh and Carlson Speak at KEMPAC Dinner 885
Dr. Scalzitti Wins Championship in KMA Golf Tournament 885
House of Delegates Votes on Assn. Name Change 894
KMA Records Show All-Time High Membership 895

REGULAR FEATURES

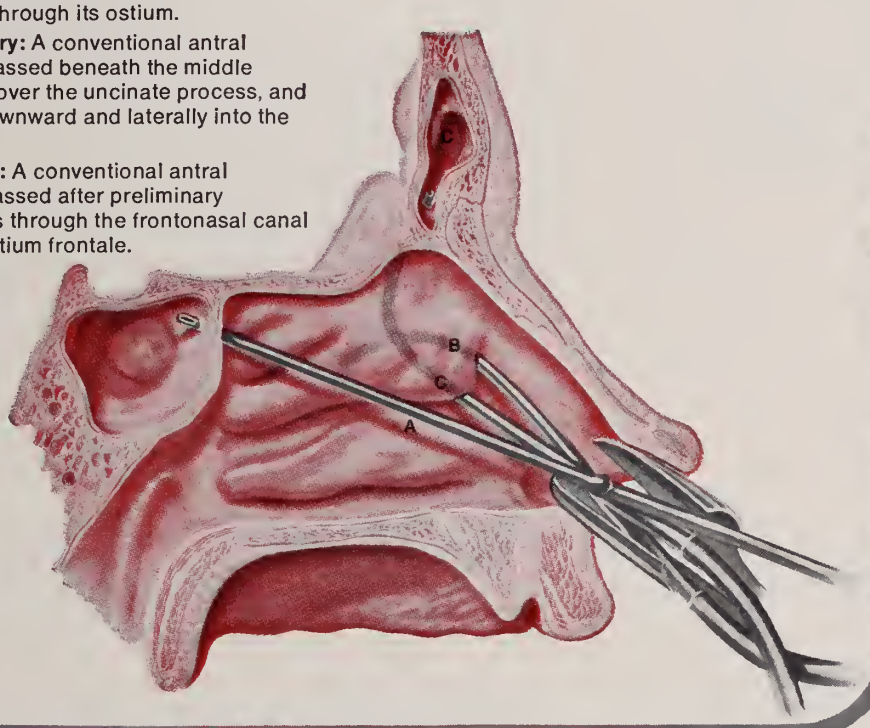
President's Page 836
Insurance Page 836
Public Health Page 840
Postgraduate Page 896
In The Books 908

A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

C—Frontal: A conventional antral cannula passed after preliminary maneuvers through the frontonasal canal into the ostium frontale.



In colds and sinusitis

Neo-Synephrine® sooner

hydrochloride
(Brand of phenylephrine hydrochloride)

can help prevent emergency measures later

Before complications arise in colds and sinusitis, Neo-Synephrine solutions and sprays reduce nasal turgescence on contact -- to promote essential aeration and drainage. Turbinates shrink, sinus ostia open and drainage is freed. Relief is instant and the threat of complications is lessened.

In the treatment of sinusitis, the ¼ per cent solution is a preferred vasoconstrictor, "... most closely approximating physiologic composition with the least 'rebound' tendency...."* Gentle Neo-Synephrine is well tolerated by delicate respiratory tissues. Systemic effects are practically nil, post-therapeutic turgescence is minimal and repeated applications do not lessen its effectiveness. Neo-Synephrine has been a standard among vasoconstrictors since 1935.

Available in plastic nasal sprays for adults (½%) and children (¼%), in solutions of ⅛, ¼ or 1 per cent.

*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

Winthrop Laboratories
New York, N. Y.

Winthrop

(1839M)

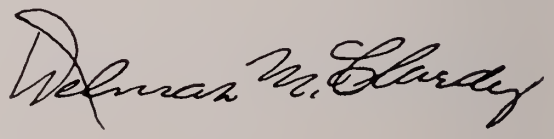
MESSAGE FROM THE PRESIDENT

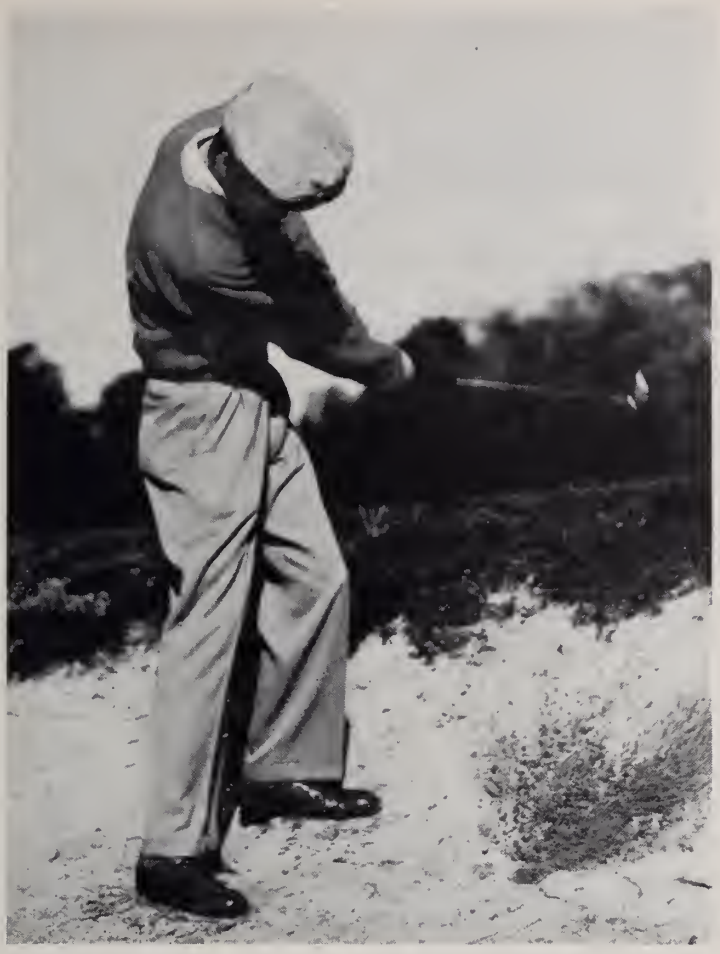


The Purpose of the Kentucky Medical Association

"THE purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and most useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life".

The above is Article II of the Constitution of the Kentucky State Medical Association. What better message could be conveyed at this time? It would be well if it could be relayed to our patients and the public in general.





Your patient doesn't have to be in the Masters to get sprains and strains

Regardless of the etiology of muscle sprain or strain, 'SOMA' COMPOUND helps relieve pain and relax muscle. Patient comfort can be increased and recovery time shortened.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

rational combination therapy for sprains and strains: relaxes muscle, relieves pain. Also available with ¼ gr. codeine as 'SOMA' COMPOUND with CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

BRIEF SUMMARY

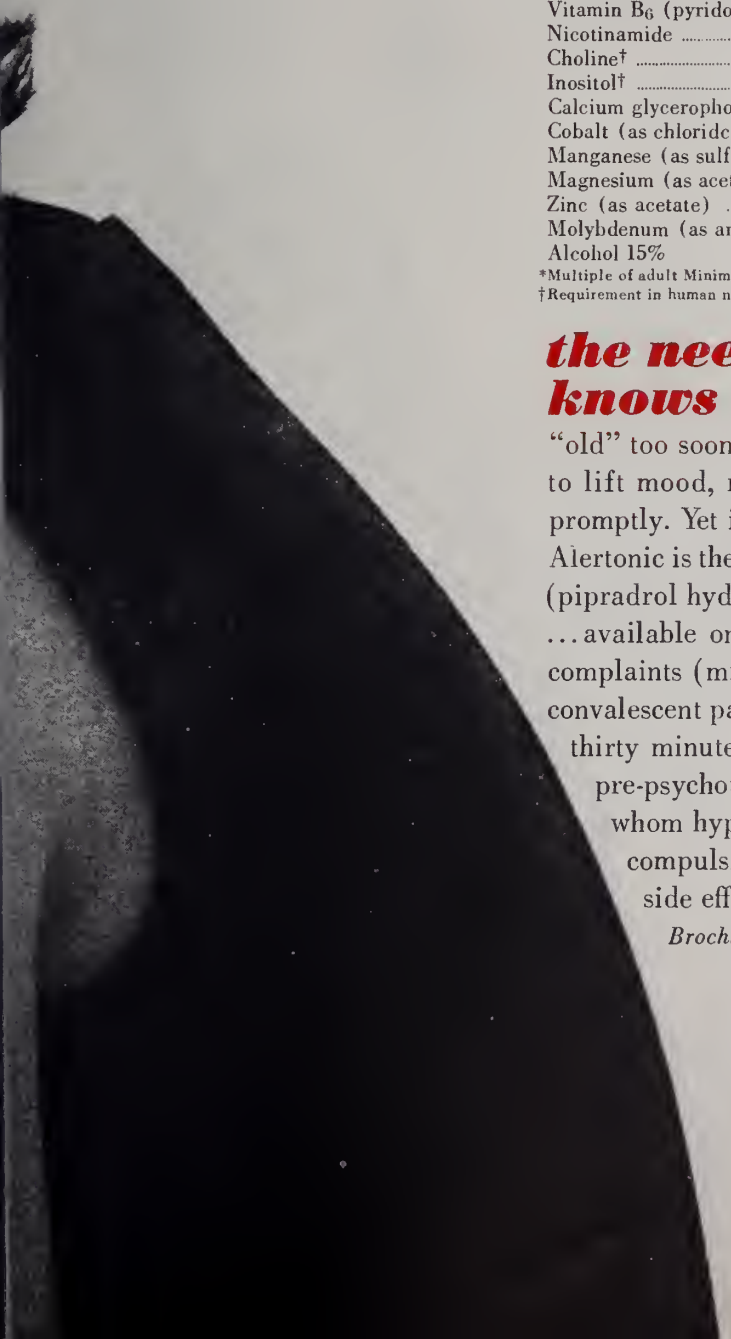
'SOMA' COMPOUND; 'SOMA' COMPOUND plus CODEINE: carisoprodol, acetophenetidin, caffeine, codeine phosphate. *Warning: Codeine may be habit-forming.* **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are indicated for relief of pain and stiffness in traumatic, rheumatic and other similar conditions. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol or codeine. **Precautions:** *Acetophenetidin*—May damage the kidneys when used in large amounts or for long periods. *Codeine*—Should be used with caution in addiction-prone individuals. *Carisoprodol*—Like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate. **Side effects:** *Codeine*—Nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is drowsiness, usually on higher than recommended doses. One instance each of pancytopenia and leukopenia occurring when carisoprodol was administered with other drugs has been reported as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. Other rarely observed reactions have included dizziness, ataxia, agitation, increase in eosinophil count, and gastrointestinal symptoms. Massive overdosage may produce coma and/or mild shock and respiratory depression. **Dosage:** 'Soma' Compound and 'Soma' Compound with Codeine, one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white, lozenge-shaped tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

CSO-3518

WALLACE LABORATORIES
Cranbury, N. J.

too young to be so tired...





revive interest... restore activity promptly with

AlerTonic®

Three tablespoonfuls (45 cc.) contain:		
Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age

Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ... available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio / Weston, Ontario



THE INSURANCE PAGE



Changing Public Attitudes Toward Medical and Hospital Care

ONE of the many interesting talks given before the recent AMA-sponsored Fourth National Congress on Voluntary Health Insurance and Prepayment was that of Carl E. Anderson, M.D., chairman of the Council of the California Medical Association.

Speaking on the role of the physician in the conservation of the health care dollar, Doctor Anderson stated that medical societies and their prepayment and insurance allies must be made aware of newly emerging socio-economic and philosophical beliefs which are being accepted by the public to an increasing degree.

Whether or not we agree with these ideas, their existence cannot be denied, and medicine must be prepared to cope with them in an informed, rational and dispassionate manner.

Among these beliefs which were mentioned by Doctor Anderson were the following:

. . . The public and each member of it has a right to receive medical care.

. . . It is not socially acceptable for illness to result in personal financial disaster.

. . . Retired people have earned for themselves the right to medical care without pauperizing themselves.

. . . It is undignified to receive charity.

. . . The hospital, regardless of ownership, is a public institution.

. . . The state, as representative of the public, has the right to control the quality and cost of medical and hospital Insurance and Prepayment Plans.

. . . The quality of medical care, both in and out of hospitals, is a legitimate area of public concern.

It was Doctor Anderson's feeling that to assure continued public acceptance of the private and voluntary system of medical practice, medicine must be prepared to assume the leadership in solving the socio-economic problems of today.

In particular, he pointed out that medical support and leadership is needed in voluntary hospital planning at all levels; that medical staffs must be concerned with hospital utilization as a matter of public responsibility; and that medicine should encourage and demand health insurance coverage (on an experimental basis, if necessary) for chronic illness, nursing home care, and psychiatric emergencies, among other components of adequate health care.

Medicine should also see to it that voluntary health insurance programs are tailored to the economic facts of life of the consumer-patient public.

In summarizing, Doctor Anderson stated that "The individual physician and his associates must clearly appreciate the existence of changing public attitudes toward medical and hospital care. Solutions of the vast problems posed by these changing attitudes can only be accomplished by direct involvement with other interested segments of society to achieve mutual education, mutual understanding of problems, and achievement of mutual goals, within the framework of social and economic reality."

W. VINSON PIERCE, M.D.

This is the season Allbee® with C is made for!



When a good old-fashioned winter proves too much for your modern-day patients, it's a comfort to know about Allbee with C. Consider its simple, rational, economical formula when patients need therapeutic amounts of B and C vitamins during the "flu" and u.r.i. season. **This is what Allbee with C is made of:** Thiamine mononitrate (B_1), 15 mg.; Riboflavin (B_2), 10 mg.; Pyridoxine HCl (B_6), 5 mg.; Nicotinamide, 50 mg.; Calcium pantothenate, 10 mg.; Ascorbic acid (vitamin C), 300 mg.

A. H. Robins, Co., Inc. Richmond 20, Va.


ALL THE YEAR ROUND

for patients who cough like the dickens... Great Expectorants by A. H. Robins

Back in Dickens' day, about the only remedy they had for a bad cough was time—and an occasional sip of rock-and-rye. Nowadays however, when dealing with bronchitis, croup, and URI, you can prescribe with "great expectations" of success by choosing one of Robins' great expectorants.

Although each Robins' antitussive is formulated for a cougher's special need, all contain glyceryl guaiacolate, a superior expectorant that produces significant increases in respiratory tract fluid (RTF) secretions.* By stimulating the natural production of RTF, glyceryl guaiacolate makes fewer coughs more productive so that the cough itself removes the very irritants that cause it.

After millions of prescriptions, no significant side effects have ever been reported from glyceryl guaiacolate. And acceptance of these elegant and highly palatable formulations by patients has always been outstanding. Whenever you treat patients who are coughing "like the dickens," give them relief with one of Robins' great expectorants.

A. H. Robins Company, Inc. Richmond, Va. 23220

ROBITUSSIN®

antitussive / demulcent / expectorant

Each 5 cc. (1 tsp.) contains:

Glyceryl guaiacolate	100 mg.

Alcohol 3.5 per cent

ROBITUSSIN® A-C (exempt narcotic)

Robitussin with antihistamine and codeine

Each 5 cc. (1 tsp.) contains:

Glyceryl guaiacolate	100 mg.
Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.

(Warning: may be habit forming)

Alcohol 3.5 per cent

Robitussin is indicated in coughs associated with head and chest colds, bronchitis, laryngitis, tracheitis, pharyngitis, pertussis, "flu," "grippe," measles, chronic paranasal sinusitis, pulmonary tuberculosis, or smoking. Robitussin A-C is especially indicated for allergic, harsh or unresponsive coughs.

dosage: ADULTS—1 tsp. every 3 to 4 hours. CHILDREN—½ tsp. every 3 to 4 hours.

side effects: No serious side effects from glyceryl guaiacolate have ever been reported. Nausea, G-I upset, and drowsiness may be encountered rarely with Robitussin A-C.

precautions: There are no contraindications for Robitussin. Robitussin A-C is contraindicated in patients hypersensitive to antihistamines or codeine.

DIMETANE® EXPECTORANT

antihistaminic / antitussive

Each 5 cc. (1 tsp.) contains:

Dimetane® (brompheniramine maleate)	2 mg.
Phenylephrine hydrochloride	5 mg.
Phenylpropanolamine hydrochloride	5 mg.
Glyceryl guaiacolate	100 mg.

Alcohol 3.5 per cent in a palatable, aromatic base.

DIMETANE® EXPECTORANT-DC

(exempt narcotic)

antihistaminic / antitussive / suppressant

Codeine phosphate	10 mg.

(Warning: may be habit forming)

Dimetane® (brompheniramine maleate)	2 mg.
Phenylephrine hydrochloride	5 mg.
Phenylpropanolamine hydrochloride	5 mg.
Glyceryl guaiacolate	100 mg.

Alcohol 3.5 per cent in a palatable, aromatic base.

Indicated for relief of cough and allergic states in which an expectorant action is useful. Dimetane Expectorant-DC is indicated when the cough suppressant action of codeine is desired.

dosage: ADULTS—1 to 2 tsp. q.i.d., as necessary. CHILDREN—½ to 1 tsp., t.i.d. or q.i.d.

side effects: Overdosage may result in mild drowsiness or excitement, but within the therapeutic range neither is likely.

Precautions: Administer with caution to patients with cardiac or peripheral vascular diseases and hypertension.

contraindications: Hypersensitivity to antihistamines or codeine. Not recommended for use during pregnancy.

references:* Boyd, E. M., and Ronan, A. K.: Am. J. Physiol., 135:383, 1942.

PUBLIC HEALTH PAGE

Encephalitis Epidemic in Danville, Kentucky*

RUSSELL E. TEAGUE, M.D., M.P.H.

Commissioner of Health Commonwealth of Kentucky

ON JULY 12, 1964, a somewhat unusual train of events was set in motion by the reporting of a case of meningitis at Kentucky State Hospital, four miles outside Danville, Kentucky. Culture of this patient's cerebrospinal fluid revealed this to be Hemophilus influenzae although Meningococcal Meningitis was the tentative diagnosis. Subsequently, on August 5, the first of 25 patients who were hospitalized, at the time of this communication, was admitted to Ephraim McDowell Hospital in Danville. CSF smears on 10 of the first 15 cases revealed a Gram negative rod, in varying numbers, identical to that found in the initial case. This organism could be cultured in only one case, that of a severely ill four-year-old boy. This organism was not seen on CSF smears or cultures in the last 10 cases. CSF findings were compared with those of patients in the Houston, Texas area where a confirmed outbreak of St. Louis Encephalitis has occurred and they are similiar. Cell counts range from 26 to 600 generally with a predominance of polymorphonuclear leukocytes, protein has usually been slightly elevated and sugar has been about normal.

Symptomatology has been similiar in all of the hospitalized cases as well as a large number of patients seen by local physicians but not requiring hospitalizing. Predominant symptoms have almost always been severe persistent headache of more than 24 hours duration, fever ranging from 101-105°, and anorexia with and without nausea and vomiting. Some have had nuchal rigidity, ocular palsies, incoherence, voice changes, and one patient has convulsed. The patients' ages range from 4 to 89 years. One death has occurred in an 89-year-old woman. Autopsy was performed but there were no gross findings of either encephalitis or meningitis. The immediate cause of death has been attributed to arteriosclerotic heart disease and pneumonia. Microscopic studies of central nervous tissue are not complete.

From the earlier cases both acute and convalescent blood specimens have been taken for serology complement-fixation studies at the State Health Department Laboratory and the Communicable Disease Center, Atlanta, Georgia.

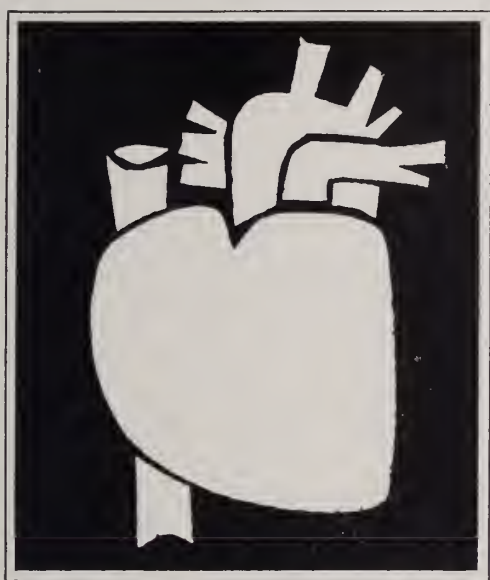
To date blood serum from a 42-year-old patient has shown an antibody titer of 1:8 to St. Louis type encephalitis antigen after 10 days of illness. An eight-year-old patient, with no titer demonstrable on serum from the acute phase of illness, has shown 1:32 titer to St. Louis encephalitis on convalescent phase serum collected 20 days after onset of illness.

Epidemiologic investigation, under the direction of the field investigator, J. Clifford Todd, is continuing. Acute and convalescent blood specimens from hospitalized patients and retrospectively from earlier suspected cases not hospitalized, are being obtained from complement-fixing antibodies, neutralizing antibodies, and hemagglutination inhibitors. Blood from various birds, chickens, and horses has been obtained to determine the extent of infections in these animals. Mosquitoes are being trapped for virus isolation.

The city of Danville was sprayed by plane on September 4 because of complaints of residents about the numbers of mosquitoes. This was done prior to the mosquito-borne disease being suspected. The State Department of Agriculture has moved into Danville with all available equipment for mosquito eradication. Fogging procedures are being carried out to kill adult mosquitoes while wet spraying is being done in all stagnant water areas to kill the mosquito larvae.

**This article was prepared by Logan Ray Campbell, M.D., Health Officer, Boyle County Health Department, Danville, Ky.*

A CLASSIC Rx
FOR A CLASSIC DIAGNOSIS



SUDDEN ONSET
ANTERIOR
VAGUE IN CHARACTER
EFFORT
SUBSTERNAL

MILTRATE®

meprobamate 200 mg. + pentaerythritol tetranitrate 10 mg.

IN ANGINA PECTORIS AND CORONARY INSUFFICIENCY

Provides long-term coronary vasodilation[1-11, 16]

Plus long-term control of anxiety in heart disease[12-16]

REFERENCES: 1. Collicelli, A., and Nardelli, A.: Treatment of angina pectoris with a combination of pentaerythritol tetranitrate and meprobamate. Policlinico (Prat.) 67:441, Mar. 28, 1960. 2. Marche, J.: Pentaerythritol tetranitrate (pentrite or pentanitrine)—a coronary vasodilator with prolonged action. J. Med. Chir. Prat. (In French) 121:252, Nov. 1950. 3. Plotz, M.: Pentaerythritol tetranitrate: A new drug for the treatment of coronary insufficiency. N. Y. J. Med. 52:2012, Aug. 15, 1952. 4. Plotz, M.: The treatment of angina pectoris with a new prolonged action pentaerythritol tetranitrate. Amer. J. Med. Sci. 239:194, Feb. 1960. 5. Russek, H. I., Urback, K. F., Doerner, A. A. and Zohman, B. L.: Choice of a coronary vasodilator drug in clinical practice. JAMA 153:207, Sept. 19, 1953. 6. Russek, H. I., Zohman, B. L. and Dorset, V. J.: Objective evaluation of coronary vasodilator drugs. Amer. J. Med. Sci. 229:46, Jan. 1955. 7. Russek, H. I., Zohman, B. L., Orumm, A. E., Weingarten, W. and Dorset, V. J.: Long-acting coronary vasodilator drugs: Metamine, Paveril, Nitroglyn, and Peritrate. Circulation 12:169, Aug. 1955. 8. Russek, H. I.: Evaluation of drugs used in the treatment of angina pectoris by means of exercise-electrocardiographic tests. Ann. N. Y. Acad. Sci. 64:533, Nov. 16, 1956. 9. Talley, R. W., Beard, O. W., and Doherty, J. E.: Use of pentaerythritol tetranitrate (Peritrate) in treatment of angina pectoris. Amer. Heart J. 44:866, Dec. 1952. 10. Winsor, T. and Humphreys, P.: Influence of pentaerythritol tetranitrate (Peritrate) on acute and chronic coronary insufficiency. Angiol. 3:1, Feb. 1952. 11. Eskwith, I. S.: Holistic approach in the management of angina pectoris. Postgrad. Med. 27:203, Feb. 1960. 12. Friedlander, H. S.: The role of ataraxics in cardiology. J. Cardiol. 1:395, Mar. 1958. 13. Russek, H. I.: Meprobamate in the treatment of angina pectoris. Amer. J. Cardiol. 3:547, Apr. 1959. 14. Shapiro, S: Observations on the use of meprobamate in cardiovascular disorders. Angiol. 8:504, Dec. 1957. 15. Waldman, S. and Pelner, L.: Modification of the anxiety state associated with myocardial infarction by meprobamate: preliminary notes. N. Y. J. Med. 58:1285, Apr. 15, 1958. 16. Koehnke, F. K.: Treatment of angina pectoris of functional origin with Corneural. Med. Klin. 54:1435, Aug. 1959.

Indications: 'Miltrate' is useful for prophylaxis of pain in angina pectoris and coronary insufficiency, especially where anxiety is a factor. **Contraindications:** Like all nitrates, pentaerythritol tetranitrate should be avoided or prescribed cautiously for patients with glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** *Meprobamate* —Patients engaged in activities requiring alertness should be warned of drowsiness. Meprobamate may increase the effects of excessive alcohol, and the possibility of dependence should be considered, particularly in patients with a history of drug or alcohol addiction. Sudden withdrawal may result in reactions, rarely epileptiform seizures. Grand mal attacks may be precipitated in persons susceptible to both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies. **Side effects:** *Pentaerythritol tetranitrate* —The most common side effects are transient headache, nausea, and rash. Weakness, palpitation, flushing, gastrointestinal distress, and lightheadedness have been reported on a few occasions. *Meprobamate* —May cause drowsiness and, rarely, ataxia, usually controlled by decreasing the dosage. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions include urticarial or maculopapular rash. Serious reactions, rarely encountered, include dermatological effects, acute nonthrombocytopenic purpura, chills, fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises, anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic, and the drug not be reinstituted. **Dosage:** Usual dosage is one or two tablets before meals and at bedtime. Individualization of dosage is required for maximum therapeutic effect. Doses above twelve tablets daily are not recommended. **Supplied:** White tablets, each containing meprobamate 200 mg. and pentaerythritol tetranitrate 10 mg. *Before prescribing, consult package circular.*

WALLACE LABORATORIES / Cranbury, N. J.

CML-4055



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

279-4

OMMEMORATING ITS *90th Anniversary*

F DEDICATED SERVICE IN THE FIELD OF PSYCHIATRY



r almost a century, THE EMERSON A. NORTH SPITAL, Inc. has been the haven and hope for human ngs distraught with nervous and mental disorders d conflicts. Located away from the tensions of the side world, situated on 40 acres of beautiful private ate grounds—this dedicated hospital offers complete chiatric treatment and care:

very advancement in the field of psychiatry, proved herapeutic methods and the most modern procedures ervices of an active medical staff composed of 20 sychiatrists, augmented by specialist - consultants rom the major medical center of Cincinnati

- ample classification facilities and qualified psychiatric nursing
- full recreational therapy facilities
- conveniences and surroundings to assure the greatest comfort and most desirable benefits
- experience and knowledge gained in 90 years of successful operation
- approved by the Joint Commission on Accreditation of Hospitals

PAUL W. WATKINS, M.D.
Medical Director

ISABELLE DAULTON, R.N.
Director of Nursing

ELLIOTT OTTE
President

GRACE SPINDLER, R.N.
Associate Director of Nursing

IRWIN C. STIRES
Administrator

Brochure and rate schedule available on request

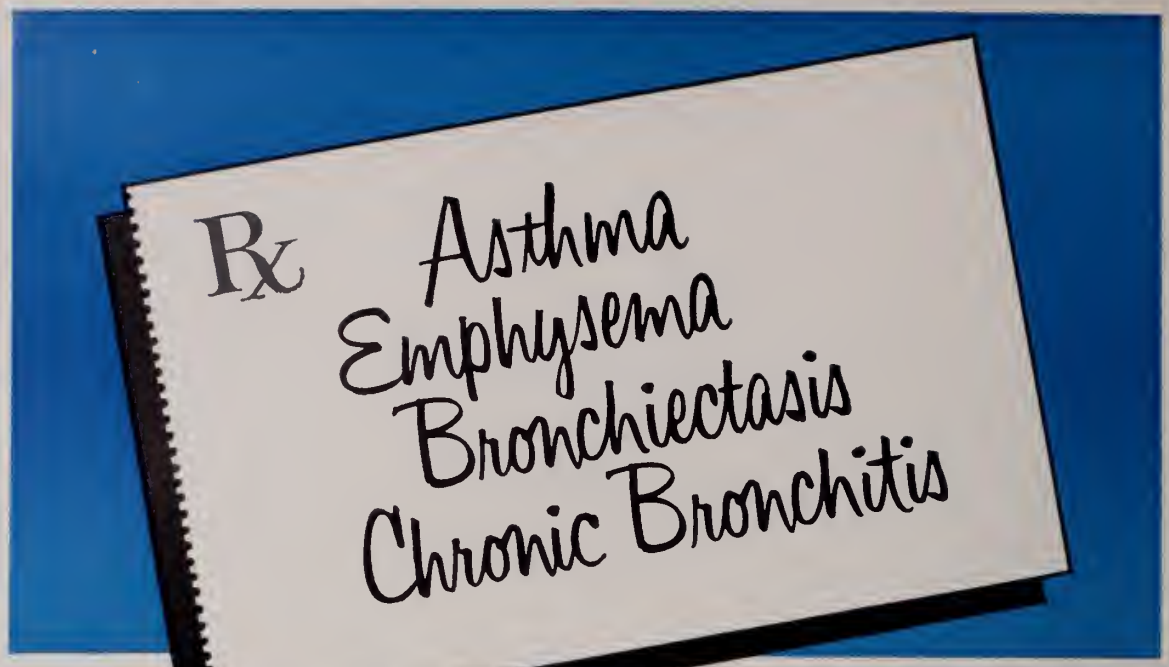
HE *Emerson A North Hospital* INC.

(FOUNDED 1874)

5642 Hamilton Avenue, Cincinnati, Ohio 45224
Telephones: 541-0135, 541-0136

Oldest private psychiatric hospital west of Alleghenies and largest in state of Ohio





mudrane®

The Bronchodilator with the intermediate dose of KI

The fast-disintegrating, uncoated tablet gives relief to the asthmatic in 15 minutes. The ephedrine-phenobarbital balance eliminates nervousness. It relaxes broncho-constriction, liquefies mucus-plugging and is buffered for tolerance.

Each tablet contains Aminophylline 130 mg., Ephedrine HCl 16 mg., Phenobarbital 22 mg. (Warning: may be habit-forming), Potassium Iodide 195 mg. Dosage: One tablet, 3 or 4 times a day. Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, and very long use may cause goiter. Iodide contraindications: tuberculosis, pregnancy. Issued in 100's, 1000's.

Also available as

mudrane® GG

Formula is identical to Mudrane except that Glyceryl Guaiacolate 100 mg. replaces the Potassium Iodide as the mucolytic expectorant. Issued in 100's and 1000's.

and

mudrane® GG ELIXIR

The formula of four teaspoonfuls Elixir equals one Mudrane GG tablet. Dosage 6 to 12 years: One to two teaspoonfuls 3 or 4 times a day. Under 6 years, adjust dosage according to age. Issued in pints and half gallons.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

"If food makes him feel good, it is not at all surprising that he will turn to it when times are tough, and his tension mounts."[1]



ESKATROL® Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

SPANSULE®

brand of sustained release capsules

controls appetite all day long with a single morning dose

relieves the emotional stress that causes overeating

Brief Summary of Principal Side Effects, Cautions and Contraindications

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

Cautions: 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

Contraindications: Hyperexcitability, hyperthyroidism.

Before prescribing, see SK&F Product Prescribing Information.

Supplied: Bottles of 50 capsules.

1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

Smith Kline & French Laboratories SK&F

NEW MEN'S SHOP



. . . in our NEW SOUTHERN

OPTICAL BUILDING, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

GUILD OPTICIANS

Southern Optical

SOUTHERN OPTICAL BLDG., 640 S. 4th
(Midway between Broadway & Chestnut)
MEDICAL ARTS BLDG., Eastern Parkway
ST. MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG., Floyd & Gray
CONTACT LENSES, 640 S. 4th



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK ®



Of 507 patients with confirmed ear, nose and throat infections... 465 or 91.7% were treated successfully with Signemycin®

Note:
Adams,* whose 50 patients included 20 with ENT infections, stated that Signemycin "was particularly valuable in infections that did not respond to other antimicrobial agents, and in patients to whom penicillin could not be given." All his cases responded within five days; in most patients, all signs of infection disappeared in three days.

*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Cured with Signemycin
Otitis media	90	86
Pharyngitis and laryngitis	162	148
Sinusitis	68	55
Tonsillitis and peritonsillitis	163	153
Various	24	23
Totals	507	465 (91.7%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017

HOW TO WIN FRIENDS...

little



New
Orange Flavored
Bayer Aspirin for Children
is sweet
all the way through,
so children
take it readily.
The GRIP-TIGHT CAP
on the bottle
helps keep them
from taking it
on their own.

Bottles of 50 tablets
(1¼ grains each)

NOW!
NEW ORANGE FLAVOR!

We will be pleased to send
professional samples on request.

THE BAYER COMPANY
Division of Sterling Drug Inc., Dept. 112
90 Park Avenue, New York, N. Y. 10016



Of 1,088 patients with confirmed skin and soft-tissue infections... 1,036 or 95.2% were treated successfully with Signemycin®

Note:
Morador et al.* obtained *excellent results in the treatment of 185 out of 191 soft-tissue infections*, all due to staphylococci. They state: "In the most serious infections occurring in patients with impaired resistance (mainly diabetics) we have had very good results in the control of the infectious condition." In these studies, incision and drainage were employed where indicated.

*Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716.

Condition	No. of Patients	No. Cured with Signemycin
Abscesses, various	35	34
Abscess, gluteal or perianal	54	52
Burns, infected	331	307
Carbuncles and furuncles	125	122
Cellulitis	104	102
Lacerations and wounds, infected	142	128
Ulcers, infected	107	106
Various superficial infections	190	185
Totals	1,088	1,036 (95.2%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017

Signemycin® Bibliography
1. Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957. 2. Arachi, N. and Gheradi, F.: Quad. Urol. 9:156, Apr.-June, 1959. 3. Arneil, G. C.: Antibiot. Ann. 1958-1959:327. 4. Arrigoni, G. et al.: Minerva Med. 48:2701, Aug. 25, 1957. 5. Baur, A.: Aerztl. Prax. 11:1845, Dec. 5, 1959. 6. Bellomio, S. et al.: Riv. Ital. Tracoma, vol. 10, Nos. 1-2, Jan.-June, 1958. 7. Bellomio, S. et al.: Riv. Ital. Tracoma, vol. 11, No. 1, Jan.-Mar., 1959. 8. Belonoschkin, B. and Lindgren, M.: Svensk. Lakartidn. 56:2134, July 31, 1959. 9. Bergdahl, U.: Svensk. Lakartidn. 55:1715, June 6, 1958. 10. Bhattacharyya, M. N. and Bhuyan, J. N.: Antiseptic 56:611, Aug., 1959. 11. Blass, R.: Schweiz. Med. Wschr. 89:158, Feb. 7, 1959. 12. Bolognesi, C.: Minerva Med. 48:2695, Aug. 25, 1957. 13. Candela, R. B.: Med. Esp. 46:273, Oct., 1961. 14. Cappelli, E.: Minerva Med. 48:2690, Aug. 25, 1957. 15. Carter, C. H. and Maley, M. C.: Antibiot. Ann. 1956-1957:51. 16. Caruselli, M. and Musca, A.: Minerva Med. 51:3516, Oct. 17, 1960. 17. Ceitlin, J.: Med. Panamer. 15:72, Aug. 1, 1960. 18. Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960. 19. Chiarenza, A.: Minerva Med. 48:2692, Aug. 25, 1957. 20. Cooper, J. et al.: Antibiot. Med. 5:302, May, 1958. 21. Cupples, J. F. B. and Perry, A. W.: Canad. Med. Ass. J. 77:699, Oct. 1, 1957. 22. David, N. A. and Carter, P. B.: Rocky Mountain Med. J. 58:27, Mar., 1961. 23. Davis, W. G.: Clin. Rev. 1:21, Apr., 1958. 24. de Lellis, J.: Dia Med., Apr. 24, 1958, p. 824. 25. Dienz, H.: Aerztl. Prax. 13:1797, 1961. 26. Dietel, V. and Meissner, F.: Deutsch. Gesundh. 16:2470, Dec. 28, 1961. 27. Dryjski, J.: Pol. Tyg. Lek. 24:1113, June 24, 1959. 28. Durrieu, C. A. et al.: Antibiot. Ann. 1958-1959:297. 29. Faz Tabio, H.: Rev. Cuba. Pediat. 30:219, Apr., 1958. 30. Febles Alonzo, D. and Batthyany, C.: Actas Ginecotocol. (Uruguay) 13:4, Aug., 1959. 31. Febles Alonzo, D. and Biderman, I.: Antibiot. Ann. 1958-1959:270. 32. Fiora, F. and Compa, F.: Dia Med., Apr 3, 1958, p. 570. 33. Garre, E.: Antibiot. Med. 7:285, May, 1960. 34. Geiger, K.: Praxis 15:365, Apr. 9, 1959. 35. Gemma, G. B. et al.: Minerva Med. 48:2643, Aug. 25, 1957. 36. Gerner, G.: Arzneimittelforschung 9:484, Aug., 1959. 37. Grazia, G.: Clin. Pediat. (Bologna) 41:1005, Nov., 1959. 38. Greco, O.: Med. Condotto-Med. Prat. 9:497, 1958. 39. Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958. 40. Henne, H. F.: Med. Klin., No. 29, July 18, 1958, p. 1267. 41. Heredia Diaz, J. et al.: Medicina (Mex.) 38:308, July 10, 1958. 42. Herrera, W. A.: Dia Med. 30:3116, Dec. 8, 1958. 43. Hoffmann, H.: Medizinische (Stuttgart) 45:1830, Nov. 8, 1958. 44. Kelleher, D.: Practitioner 182:227, Feb., 1959. 45. Kleine, W. and Hagen, H.: Ther. Gegenw. 98:171, Apr., 1959. 46. Klovstad, O.: T. Norsk. Laegeforen. 77:681, Aug. 15, 1957. 47. Kobari, K. and Tajiri, I.: Naika No Ryoiki (Field of Internal Medicine) 7:245, May, 1959. 48. Kohler, H. F.: Clin. Rev. 1:16, Apr., 1958. 49. Kraljevic, R. et al.: Antibiot. Med. 5:364, June, 1958. 50. La Caille, R. A. and Prigot, A.: Antibiot. Ann. 1956-1957:67. 51. Lapeyre, L. et al.: Marseille Med. 99:953, 1962. 52. Levi, W. M., Jr. and Kredel, F. E.: J. S. Carolina Med. Ass. 53:178, May, 1957. 53. Loughlin, E. H. et al.: Antibiot. Ann. 1958-1959:293. 54. Loughlin, E. H. et al.: Antibiot. Med. 7:739, Dec., 1960. 55. Mathur, S. N. and Joshi, V. S.: J. Indian Med. Ass. 34:437, June 1, 1960. 56. Moggian, G.: Minerva Med. 48:2648, Aug. 25, 1957. 57. Molinelli, E. A. et al.: Antibiot. Ann. 1957-1958:692. 58. Montilli, G. and Avellino, M.: Dermatologica (Basel) 9:2, 1958. 59. Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716. 60. Morador, J. L. and Saldana Tate, L.: An. Ateneo, Clin. Quirur. 1:52, Jan., 1958. 61. Morel, A. S.: Clin. Rev. 1:18, July, 1958. 62. Morey, G. S. et al.: Rev. Hosp. Nino (Lima) 18:293, 1957. 63. Ottolenghi, C. E. et al.: Bol. Soc. Cir. B. Air. 41:739, Nov. 6, 1957. 64. Pagola, J. G. et al.: Antibiot. Ann. 1958-1959:287. 65. Pavone, M. et al.: Minerva Urol. 70:121, Sept.-Oct., 1958. 66. Porrazzo, F.: Gazz. Med. Ital. 118:550, Dec., 1959. 67. Prats, F. and de la Parra, M. A.: Antibiot. Ann. 1959-1960:484. 68. Prokop, O.: Prakt. Arzt. 12:145, Feb. 15, 1958. 69. Ramirez Boettner, C. M. et al.: Rev Med. Paraguay 5:269, July-Sept., 1960. 70. Randig, K.: Deutsch. Med. J. 8:447, Aug. 15, 1957. 71. Saavedra Amaro, S. and Lopez Zepeda, L.: Medicina (Mex.) 38:396, Aug. 25, 1958. 72. Saldana Sotomayor, F.: Medicina (Mex.) 39:191, May 10, 1959. 73. Santos, A.: Rev. Brasil. Med. 16:463, July, 1959. 74. Schenone, H.: Antibiot. Ann. 1958-1959:316. 75. Schunk, A.: Int. Rec. Med. 173:143, Mar., 1960. 76. Sgarzini, L. and Amato, R.: Ann. Stomat. 7:499, July, 1958. 77. Shubin, H.: Antibiot. Med. 4:174, Mar., 1957. 78. Sundberg, R. H.: Antibiot. Med. 7:115, Feb., 1960. 79. Talbot, J. R.: Wisconsin Med. J. 57:237, June, 1958. 80. Tato, J. M. et al.: Antibiot. Ann. 1957-1958:675. 81. Weithofer, W.: Medizinische (Stuttgart) No. 33-34:1490, Aug. 22, 1959. 82. Willcox, R. R. and Rosedale, N.: Brit. J. Vener. Dis. 38:19, Mar., 1962. 83. Willemot, J. P. et al.: Bruxelles Med. 38:1026, June 22, 1958. 84. Winton, S. S. and Chesrow, E. J.: Antibiot. Ann. 1956-1957:55. 85. Wolman, B.: Practitioner 185:199, Aug., 1960. 86. Yodh, B. B.: J. J. J. Group Hosp. 5:183, July, 1960. 87. Zaldivar, C. G. and Falcone, F. L.: Rev. Hosp. Nino (Lima) 20:141, June, 1958.

SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017



Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017



and it's not a once-over-lightly one, either. All rubber stoppers used in Lilly ampoules are scrupulously cleaned with a detergent and hot deionized water in a special washing machine like the one pictured above. This removes any foreign matter adhering to them. Then the stoppers are autoclaved at 120° to 121°C. for one hour. They are now clean, sterile, and ready for use. In case the stoppers are not used within seventy-two hours, they are returned for resterilization. □ This meticulous process is only one of the many safeguards to insure the quality of the finished product and to protect the ultimate user.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

401196

The JOURNAL of the
Kentucky Medical Association

Issued Monthly Under The Direction Of The Board Of Trustees

VOLUME 62 November, 1964 No. 11

Pheochromocytoma: Recent Experiences With Two Cases

Benjamin B. Jackson, M.D., F. A. C. S.,*
James E. Bryan, M.D.,** and F. Albert Olash, M.D.***
Louisville, Ky.

Pheochromocytoma appears to be an increasing cause of curable hypertension. Elevated V.M.A. and urinary catechol amines are required before exploration can be soundly advised. Patient survival requires constant early postoperative vigilance.

THOUGH the etiology of hypertension frequently is obscure, the complications are vivid. Since some forms of hypertension may be curable, an awareness of remediable lesions is necessary. The clinical history may arouse suspicion but an aortogram is required to disclose renal stenosis, the serum potassium determination to reveal an aldosterone secreting tumor, and the tests for vanillyl mandelic acid or urine catechol amines to confirm the presence of pheochromocytoma. Presently, it appears that the growing incidence of pheochromocytoma is a reflection of improved diagnosis, for more cases have been reported during the last ten years than in all previous decades. The incidence is considered to range from 0.35 percent to 0.45 percent of all hypertensives.[1] Two additional cases of pheochromocytoma are herewith reported to affirm that some measure of success can be achieved by correct diagnosis and surgical ablation.

The undiagnosed pheochromocytoma is a notorious harbinger of hypertensive sequelae. The devastating effects on the coronary circulation as well as cerebral sufficiency are well documented. The lethal dissecting aneurysm occupies a significant niche in the mortality charts. Sustained hypertension may cause sufficient renal damage to induce persistent post excision elevation of blood pressure. Unsuspected pheochromocytomas strikingly increase the incidence of operative deaths from unrelated surgical procedures. The mortality in children and pregnant females with an undetected pheochrocytoma is also forebodingly high[4]. Those features alone are reason enough for early disclosure and resection.

Apparently, hypertension induced by the pheochromocytoma develops from execssive liberation of nor-epinephrine and/or epinephrine into the systemic circulation. Epinephrine is produced only by the adrenal medulla whereas nor-epinephrine is manufactured by both the adrenal and sympathetic ganglia or nerve endings[3]. Usually, the release of those vasoactive agents is spasmodic and the response is experienced as attacks or crises. However, one of three patients exhibits sustained blood pressure elevation. Nor-epinephrine mediates its effect by potent vasoconstriction of the arteriolar circulation. Peripherally, it is sixty

*Clinical instructor in surgery and research associate at the University of Louisville School of Medicine.
**Clinical instructor in Medicine, University of Louisville.
***Clinical instructor of Medicine, University of Louisville.

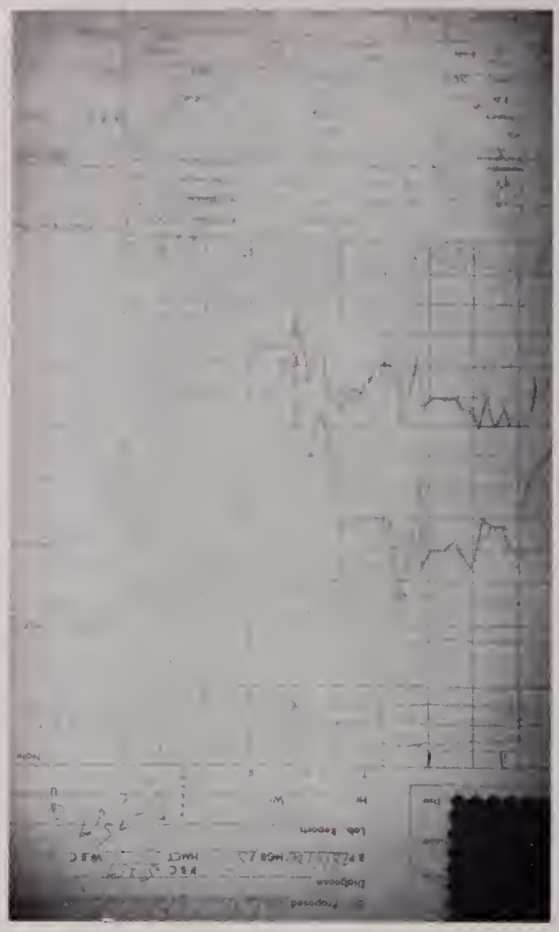


Figure 1 — Anesthesia chart on Case #1, H. C.: Explosive elevation of blood pressure during manipulation of the pheochromocytoma followed by sharp depression after excision.

times more active than epinephrine whose prime effect appears to be on cardiac output and glycogen metabolism. Dizziness, tremulousness, convulsions, and peripheral mottling indicate a chromaffin tumor elaborating principally non-pinephrine. Rise in blood sugar with glycosuria, elevated temperature and pulse rate, and hypermetabolism manifested by increased oxygen demand suggest a predominant release of epinephrine.

Case #1, H. C.—This fifty-nine year old white, male, lathe operator was well until eighteen months prior to admission when he began to experience headaches, palpitations, dizziness, and blurring of vision. He was brought to the emergency room of the Norton Memorial Infirmary with a left hemiparesis. At the time of the initial admission, his blood pressure was 240/110. He was febrile, sweaty, and confused. After three days of hospitalization, the hemiparesis cleared and he insisted on being discharged. He was subsequently followed in the office of one of us (JEB) for further evaluation of his hypertension. An intravenous phentolamine (Regitine®) test produced an abrupt fall in blood pressure from 190/100 to 60/0. With this provocative test, the patient was readmitted to the hospital. The urinary catechol amines were significantly elevated. X-rays failed to delineate the lesion.

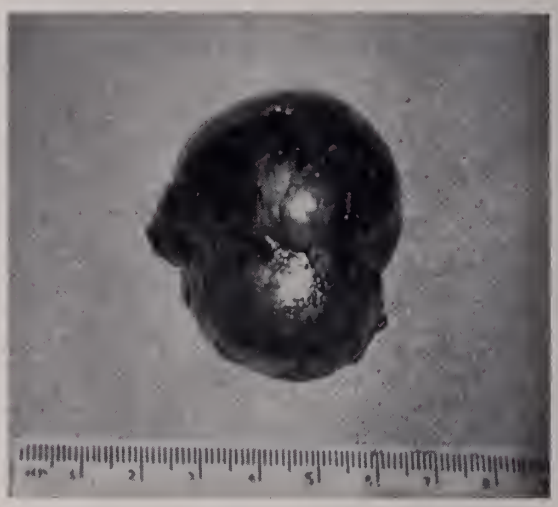


Figure 2 — A pheochromocytoma of the right adrenal gland weighing 50 grams removed from Case #1, H. C.



Figure 3 — Cross section of pheochromocytoma removed from Case #1, H. C.

The patient was explored through an upper abdominal transverse incision. A lemon sized, solid mass was discovered incorporating the upper pole of the right adrenal gland. During dissection, the blood pressure spiked to 300/40. Intravenous phentolamine dropped the blood pressure to safer operating levels. As soon as the tumor was excised, the blood pressure was unobtainable. Four ampules of 0.2 percent levarterenol solution in each 1000 cc. of 5% dextrose and water were required for ninety-six hours to maintain blood pressure at

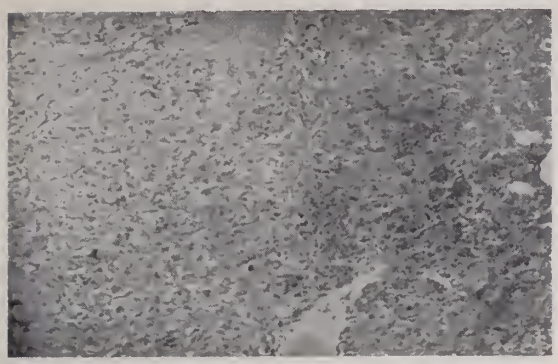


Figure 4 — Histologic section from a representative area of the pheochromocytoma removed from Case #1, H. C.

a systolic level of 100 millimeters of mercury. On the fifth postoperative day, the levarterenol could be discontinued but when the patient was erect, the blood pressure could not be recorded. However, by the seventh postoperative day, the blood pressure was consistently 104/60 when he was upright.

A four-year follow-up revealed his blood pressure as stable between 140 to 150 over 90 mm.Hg. He has undergone two subsequent surgical procedures without event. There have been no additional hypertensive crises.

Case #2, L. H.—This fifty-one year old, obese, white, male, post office inspector began to notice episodic attacks of blood pressure elevation fourteen months prior to admission to the Norton Memorial Infirmary. During the crises, he complained of throbbing pain in the right side of the neck extending cephalad over the temple area. He described the attacks as loss of control and tremulousness. During the crises his blood pressure soared to 220 to 240 over 110 to 130 mm.Hg. Ordinarily, his blood pressure ranged from 140 to 160 over 85 to 95 mm.Hg. A workup by one of us (FAO) divulged elevation of two consecutive vanillyl mandelic acid tests, but two tests for urinary catechol amines were borderline. A retrograde aortogram intimated a tumor of the right adrenal gland.

Accordingly, he was explored through an upper transverse abdominal incision. The right adrenal was enlarged and cystic. The left adrenal was normal to palpation and inspection. No other lesions were uncovered along the sympathetic chain or near the aortic bifurcation. The right colon was reflected and the right adrenal mobilized. Concomitant with the dissection, the blood pressure rose to 220/110. Upon ligation of the adrenal veins, it rapidly fell to 80/40. He withstood the procedure well but required two ampules of 0.2 percent levarterenol solution in each 1000 cc. of 5% dextrose and water for the first twenty-four hours. After the first postoperative day, his blood pressure stabilized at 150/80. His course was not plagued with orthostatic hypotension. He was discharged on his eighth postoperative day.

Histological examination of the right adrenal gland disclosed cystic degeneration of a benign neoplasm of the medulla. Silver stains confirmed a pheochromocytoma.

An eighteen month follow-up reveals no further attacks of hypertension. The blood pressure apparently has leveled off at 140 to 160 over 80 to 90.

Discussion

Certain suggestions and clues might be helpful in uncovering a functioning chromaffin tumor. Pheochromocytoma is rare but probably less so than was formerly presumed. Any evaluation of hypertensive cardiovascular disease should exclude an adrenal tumor. Familial occurrence suggests a genetic mechanism[8]. Neurofibromatosis has been recorded in five to twenty percent of all pheochromocytomas[5]. Calcification in the area of the adrenal gland in the hypertensive patient suggests a pheochromocytoma. Palpable tumors occur in about fifteen percent of the cases[2]. The standardized phentolamine test is a satsfactory screening measure. The histamine test has little to recommend it. The vanillyl mandelic acid or the urinary catechol amines should be determined to be elevated before exploration can be soundly advised. However, the tests have little significance in intermittent hypertension if the urine collections are not made during the crises. Antihypertensive drugs should also be omitted prior to tests for pressor amines[6].

Unless the neoplasm is large, it is impossible to be certain of its exact location. The operator must be prepared for anatomical dissection of either adrenal, sympathetic chain, or aortic bifurcation. The upper abdominal transverse incision has been advocated by many. Scott, however, is a proponent of the upper mid line incision with extension into the appropriate pleural cavity[7]. There seems to be little justification for the flank incision except in dealing with palpable tumors. Since multiplicity is encountered in approximately ten percent, all ectopic areas must be examined. Failure of blood pressure to drop following resection of a

pheochromocytoma sugggest residual chromaffin tumor. Malignancy ocurs in about ten percent and the resectability rate is low due to invasion of adjacent vessels. Also, malignancy portends sustained hypertension with rapid deterioration of the cardiorenal system.

During the operative dissection, success is often dependent on a reliable venous cut down for administration of phentolamine or levarterenol. One individual in the operating room is designated to record the blood pressure every thirty seconds during and immediately after excision of the tumor. Until the adrenal veins are clamped, there is continuous elaboration of vasoactive substances from mechanical manipulation of the gland. This may cause explosive elevation of the blood pressure which must be diligently regulated by phentolamine. Arrhythmias are also common. A cardiac monitor is of some merit here. Early post excision levarterenol requirements must be carefully titrated against the hypotension. The levarterenol demands are, no doubt, a reflection of the amount of epinephrine-like substance previously liberated by the tumor and the labile vasomotor stability of the arteriolar circulation. Postoperatively, the patient is rapidly weaned from levarternol because of the hazards of mucosal necrosis in the gastrointestinal tract.

Follow-up discloses that in almost all reported cases the hypertensive crises have been eliminated. Occasionally, a patient will be encountered who has renal disease superimposed on a preochromocytoma. The most that can be hoped for under those circumstances is freedom from attacks. Obviously, there are few occasions when such vigorous, coordinated attention is demanded of the internist, surgeon, and anesthesiologist. Failure to observe the most minute details in the management of the patient who has become accustomed to high circulating levels of epinephrine-like substances may well lead to death. The results are usually gratifying and this seems ample reward for the time and anxiety required for evaluation, surgical excision, careful anesthesia, and postoperative care.

Summary and Conclusions

The complications of hypertension demand that a pheochromocytoma be excluded in each hypertensive patient. The diagnosis is suggested by a clinical history of erratic or sustained hypertension, peripheral vasoconstriction, hypermetabolism, and glycosuria. Elevated VMA and urinary catechol amines are required for confirmation. Multiple tumors are known to exist in approximately ten percent. Ectopic pheochromocytomas have been reported in eight to ten percent. Malignancy has also been observed in about eight percent of the cases. Attention to minute details, pre and post excision, is demanded for patient survival. Two patients who have undergone successful resection of pheochromocytoma are reported.

References

1. Graham, J. B.: *Pheochromocytoma and Hypertension: analysis of 207 cases.* Surg. Gyn. and Obst., International Abst. Surg. 92: 105, 1951
2. Glenn, F., Mannix, H., Jr.: *The Surgical Management of Pheochromocytoma.* Surg. Gyn. and Obst. 116: 613, 1963.
3. Hardy, J. D., Carter, T. Turner, M.D.: *Catechol Amine Metabolism.* Ann. of Surg. 150: 166, 1959
4. Hume, D. M.: *Pheochromocytoma in the Adult and in the Child.* Am. J. Surg. 99: 458, 1960.
5. Miles, R. M.: *Pheochromocytoma: A review of ten cases.* Arch. of Surg. 80: 238, 1960.
6. Priestly, J. T., Kvale, W. F., Gifford, R. W., Jr.: *Pheochromocytoma.* Arch. of Surg. 86: 778, 1963.
7. Scott, H. W.: Discussion of Paper, Miles, R. M.: *Pheochromocytomas: Interesting Experiences in three cases.* Ann. of Surg. 149: 925, 1959.
8. Tisherman, S. E., Gregg, F. J. Danowski, T. S.: *Familial Pheochromocytoma.* J.A.M.A. 182: 142, 1962.

Mark your calendar now

to attend the

KMA Interim Meeting—March 18, 1965

Gabe's Restaurant *Owensboro, Ky.*

Liver Biopsy: A 10 Year Survey at Louisville General Hospital

F. Norman Vickers, M.D.* and David P. Price, B.A.**
Louisville, Ky.

Experience with 389 liver biopsies confirms the reported low mortality. Diagnostic accuracy has shown a progressive increase. In the past two years, this procedure has been helpful in diagnosis in over 80% of cases.

THE first large series of percutaneous liver biopsies was reported by Iverson and Roholm in 1939.[1] Since that time, the procedure has been performed increasingly for diagnostic purposes and now enjoys wide acceptance. Recent changes in needle design have simplified the biopsy technic. In the last 10 years at The Louisville General Hospital, 3 different biopsy needles have been in use. In accord with the trend toward increasing frequency of liver biopsy, we have come to rely on this diagnostic aid in a number of clinical situations. It was felt that review of our experience during this 10 year period in regard to diagnostic accuracy, number of biopsies performed and safety of the procedure would be of interest.

Materials and Methods

Charts were reviewed from May 1954 to May 1963 with special attention to admission clinical diagnoses, histopathologic reports on liver biopsy, subsequent clinical course including autopsy reports where available and type of biopsy needle. Histologic sections were reviewed in cases of special interest and where it appeared that the interpretation might have changed in the light of further clinical evidence. Since July 1961, all liver biopsies have been reviewed in evaluation of patients by the senior author. Biopsy specimens were classified according to their relationship to the provisional clinical diagnosis. These were categorized as follows:

I. Helpful in diagnosis
   A. Confirmed the clinical diagnosis
   B. Corrected the clinical diagnosis

II. Of no help in diagnosis
   A. Noncontributory
   B. Inadequate specimen

The biopsy procedure is designed to secure tissue which is adequate for histopathologic study; failure to achieve an adequate sample precludes clinicopathological correlation and thereby adds nothing. In focal liver disease, the findings may be misleading through failure to sample the morbid process. Since many feel that fatty metamorphosis is a precursor of nutritional cirrhosis,[2] for classification purposes fatty metamorphosis of the liver was included in the clinical constellation of portal cirrhosis.

Not all clinical records stated the type of biopsy needle used. However, only the Vim-Silverman needle was used from 1954 until 1957. In 1957 the Franseen needle became available at our hospital and was the type most widely used from 1957-1961. In July, 1961 the Menghini needle became available and since that time has been the preferred instrument.

For more detailed discussion of the actual technic of liver biopsy, indications, and needle types chapter no. 6 in Schiff's *Diseases of the Liver* is highly recommended.[3]

Needle Types

The Vim-Silverman needle[4] is the instrument which has had the most extensive use in liver biopsy. This is a split needle for punch biopsy with an outer cannula. The split needle is introduced into the liver and the outer cannula is advanced over the needle thus separating the biopsy core from the rest of the liver. This needle delivers a specimen of 1 mm. diameter. A moderate amount of manual dexterity is required by the operator, and the patient is required to hold his breath for about 30 seconds during the procedure.

* *Assistant professor of medicine, University of Louisville School of Medicine*

** *Senior Medical Student, University of Louisville School of Medicine*

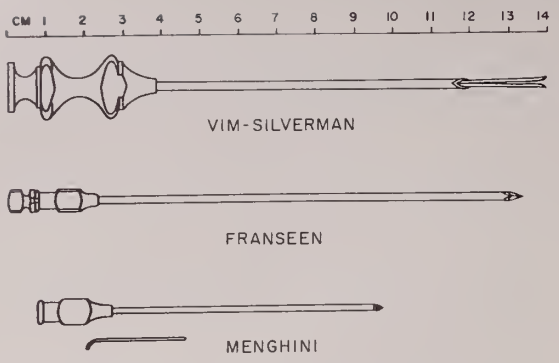


Figure 1. The three types of needles used in this study are shown. Note the relative sizes of the three.

The Franseen needle is an aspiration type biopsy instrument with its own trochar and cutting edges on the needle tip.[5] After the hollow needle is advanced into the liver, a saline filled syringe is attached and gentle aspiration is applied while the needle is withdrawn. The time required for breath-holding is only about 15 seconds. It is the general procedure to make only one attempt to obtain liver tissue with the Vim-Silverman or Franseen needles. Occasionally, if no liver tissue is obtained, a second attempt is made at that time.

The Menghini aspiration biopsy needle is the shortest of the three and delivers a specimen 1.2 mm. in diameter.[6] Several bores are available but the 1.2 mm. is used most often. Since the needle is introduced with an aspirating syringe attached, breath-holding time is only about five seconds. Indeed, Professor Menghini calls this procedure the "one-second biopsy," but we usually perform the maneuver more leisurely than this.

Although the Menghini needle provides a relatively short specimen, multiple biopsies can be obtained with greater ease and safety. Our present routine involves two consecutive attempts to aspirate tissue at the time of the initial biopsy. If this provides no tissue, two or three additional aspirations may be carried out safely.

Since all three needle types are satisfactory, the main reason for preference of the Menghini is that it requires the least number of manipulations to obtain an adequate specimen, and since it is the smallest of the three, it should offer some theoretic advantage as far as post-biopsy hemorrhage is concerned. Hence, it seems best adapted for teaching the technic of liver biopsy.

Morbidity and Mortality

In this series, there was only one death which might be attributable to liver biopsy. Biopsy was performed in 1954 with the Vim-Silverman needle in a debilitated man who died 18 hours later without signs of peritonitis or drop in hemoglobin concentration. Autopsy was refused, so that exact cause of death could not be determined. However, attributing this one death to liver biopsy in 389 procedures gives a mortality rate of 0.26%. Liver biopsy, thus, has been a relatively safe procedure in our hands using the standard precautions.[3] Our apparent mortality rate was higher than that of Terry[7] whose compilation of 10,600 reported cases revealed a mortality of 0.12%.

In a study of this type, morbidity is somewhat difficult to quantify. The most common complaint was mild pain at the biopsy site. This was present in about 15% of the overall series; it was transient and usually required only mild analgesics. No episodes of bile peritonitis or significant pneumothorax were produced. We have the impression that the Menghini needle produces the least amount of post biopsy pain. In fact, a few patients with chronic liver disease who have had biopsies with all three needles have expressed a definite preference for this needle.

Aid in Diagnosis

As outlined above, the periods in Fig. 2 are divided according to the needle type in predominant use. The percentage of inadequate specimens showed a progressive decrease during each period. It should be pointed out that from 1954 to 1957 biopsies were performed by internists or by house officers under their supervision. Since July 1957 almost all biopsies have been performed by or under the supervision of the staff of the gastroenterology section. Since July 1961 approximately half of the liver biopsies have been performed by or directly under the supervision of the senior author.

The percentage of positive aid in diagnosis for the three periods has been 63, 75, and 85 per cent respectively. No doubt, this increase is in part due to the decreasing number of inadequate specimens. Also affecting the number of confirmed diagnoses was the fact that, with the increasing ease and safety of biopsy, serial biopsies were performed more frequently in order to follow more completely the course

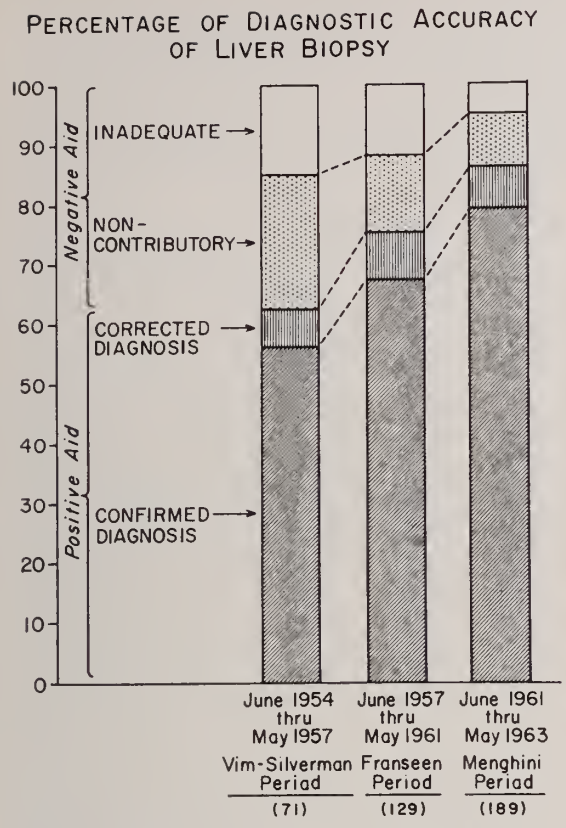


Figure 2. This figure shows the percentage of liver biopsies assigned to each category. Note that the number of inadequate specimens gets progressively smaller and the per cent of liver biopsies which corrected the clinical diagnosis remains at about 8 per cent. The number of biopsies in each period is in parentheses.

of chronic liver disease. Indeed, one relatively young patient with alcoholic cirrhosis and pancreatitis had a total of nine liver biopsies.

Figure 3 shows the increase in number of biopsies performed per year. The part years of 1954 and 1963 were not included in order to show only complete years. The slight drop in number of biopsies performed in 1962 may be due to the fact that there was no senior resident assigned exclusively to the gastroenterology service for the last six months; hence, there was one less person available to perform or teach this technic.

Biopsies which result in revision of clinical diagnosis are of greatest diagnostic value when they occur. It is interesting that these remain about 8 per cent of the total during each of the three periods. Diagnoses in this category include amyloidosis, sarcoidosis, histoplasmosis, tuberculosis and primary and metastatic neoplasms of the liver. In regard to metastatic cancer, Conn and Yerger[8] point out that among all livers containing metastatic cancer 50 per cent will show cancer on one random needle

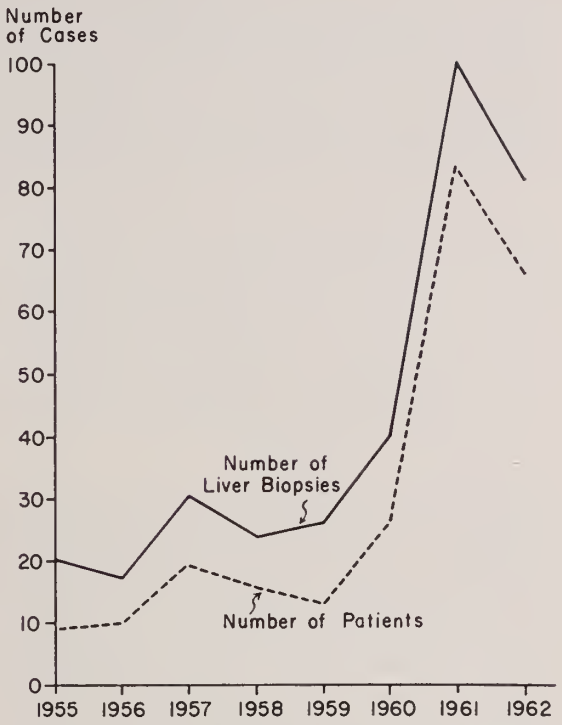


Figure 3. This figure shows the number of liver biopsies and the number of patients per year. The portions of 1954 and 1963 which were included in this survey were not included in order to show only complete years.

biopsy specimen. By the time there are clinical signs of cancer of the liver, a single needle biopsy will yield malignant tissue approximately 90 per cent of the time. Consequently, they advise liver biopsy in all cases of carcinoma in the thorax about to undergo resection for cure to help rule out those with carcinoma already metastatic to the liver.

Summary and Conclusions

Percutaneous liver biopsy at The Louisville General Hospital for the last 10 years has been reviewed. There was one death in 389 biopsies, a mortality rate of 0.26 per cent. When biopsy was performed by various groups on the medical service, the mortality was low but positive aid in diagnosis was approximately 60 per cent. When biopsy was performed with the Menghini needle under supervision of one group, the diagnostic accuracy exceeded 80 per cent. Because of the safety and accuracy of the procedure, we have come to rely increasingly on liver biopsy in evaluating patients with liver disease.

References

1. Iversen, P., and Roholm, K.: *On aspiration biopsy of the liver, with remarks on its diagnostic significance,* Acta. med. scand. 102: 1-16, 1939.

2. Hartoft, W. S.: *Accumulation of fat in liver cells and in*

Continued on Page 906

Management of the Occiput Posterior*

Robert J. Griffin, M.D.
Lexington, Ky.

A previously described method of one finger rotation of the occiput posterior for delivery was employed 92 times in 1000 consecutive deliveries. After rotation, 52 per cent of them delivered spontaneously.

MEDICAL literature over the years has had a great number of articles dealing with problems in management of the occiput posterior in obstetrics. This attests that a perfect management has not yet been found. An obstetrician may adopt a method, or methods, which are satisfactory to him in his hands, but the same method might not appeal to another. Skill in this field is attained only by repeated trial, and a realization that all rotations cannot be accomplished with equal ease.

Certain principles have evolved in dealing with the occiput posterior which I believe are being taught to present day medical students. These principles include:

1. If forceps rotation is to be done, a forceps should be selected which has very little pelvic curve.
2. The principles of Bill[1] are an improvement over the original Scanzoni.
3. Manual rotation, when it can be accomplished, in the hands of most operators is safer for the mother and baby than is forceps rotation.
4. The vacuum cup extractor appears to have some potential as a rotator. I have had no experience with this instrument.

An appreciable percentage of heads engage in the occiput posterior position, especially in the anthropoid type of pelvis. No very reliable figures are available as to what actual percentage begin as posteriors, since the majority, in time, tend to rotate spontaneously. The patient, conservative obstetrician is therefore gratified when the forces of uterine contractions plus an eventually dilated cervix, plus the pelvic plane factors, result in rotation. The time required, however, may be exhausting to the mother, inimical to the welfare of the baby, and exasperating to the obstetrician.

An effective, non traumatizing assistance to the natural tendency toward rotating in the first stage of labor would be ideal. It can only be done when the cervix is fully dilated or nearing full dilatation.

As a resident in obstetrics I was taught to do manual rotations whenever possible in the interest of safety. I was never too skillful with the conventional methods such as the Danforth[2] method of grasping the head as one would a baseball, or other procedures. Often the head was displaced upward to an undesirable station for forceps application. I conceived of the idea of using two fingers as a fulcrum to direct the occiput anterior during a contraction. I met with only indifferent success in my efforts, and gave up the idea.

The Maneuver

In September 1947, at the annual meeting of the Kentucky State Medical Association, the late Dr. C. J. McDevitt, a former president of this Society, presented a paper in which he described one finger rotation of the occiput posterior.[3] I shall read his description of the method as he presented it:

"The maneuver which I have used for the past four years is this: With the patient well sedated but not beyond the cooperative state, the cervix completely dilated and effaced, the head in the pelvis and the bladder empty, she is given 4 or 5 deep breaths of nitrous oxide at the beginning of a contraction and then told to bear down. The anterior suture of the three sutures that make up the "Y" of the posterior fontanelle is then grasped by the index finger and force exerted toward anterior rotation without upward pressure. It is easier to use the right index finger in the left posterior position and the left index finger in the right posterior position." Dr. McDavitt stated that after rotation the primagravidas were usually delivered

* *Presented at the Kentucky Obstetrical and Gynecological Society meeting at Lexington, Kentucky, May 9, 1963.*

by forceps, while the multigravidas were usually allowed to deliver spontaneously.

This concise description of a rather simple procedure was confidence inspiring and I was encouraged to pursue the method with renewed interest. The only thing that I have added to the maneuver is to use the free hand to exert pressure on the diagonally opposite pole of the uterus during the contraction. In other words, with an LOP position the right index finger is employed on the anterior angle of the lambdoidal suture, exerting pressure to effect rotation, while the left hand is used at the right cornua, or right upper extent of the fundus, to exert pressure downward. This, I have found, adds much to the success of the maneuver. Counter pressure from the diagonally opposite pole appears to give a spiral motion to the fetal ovoid.

Poor flexion of the fetal head is one of the factors in improper rotation, especially in the occiput transverse position. It is often found that as progress is made with successive contractions, the finger or two fingers, may actually be hooked around the occiput so that rotational and downward pressure causes a dramatic increase in flexion of the head, with now readily completed rotation.

In order to evaluate the frequency and adequacy of this method of dealing with the posterior occiput, I decided to determine how it fit into the total experience of 1000 consecutive deliveries. About a year and a half ago I took the past 1000 consecutive deliveries from private practice to arrive at this profile. Figure 1 shows the positions, or general management problems in the group studied.

Occiput Anterior	
Spontaneous	487
Forceps	314
Occiput Posterior	133
Brow (delivered as brow ant.)	4
Military	1
Breech	31
Caesarean Sections	30
Total	1000

Figure 1. Profile of 1000 consecutive deliveries. Percentages may be readily visualized by placing a decimal in front of the ones digit.

Figure 2 gives a break down of the occiput posteriors and the manner in which they were handled.

Occiput Posterior (13.3 percent of 1000 deliveries)	133	
Method of delivery	number	percent of posteriors encountered
Spontaneous as Posterior	2	1.5
Forceps as Posterior	2	1.5
Manual rotation 1 finger	92	69.1
(Spontaneous Del.)	48	
(Forceps Del.)	44	
Manual rotation (conventional & forceps)	6	4.5
Bill	17	12.7
Scanzoni	1	0.7
Manual rotation 1 finger to transverse & forceps (Key-in-lock)	12	9.0
Kielland forceps	1	0.7

Figure 2. Management of 133 occiputs posterior positions occurring in 1000 consecutive deliveries.

Discussion

A certain amount of patience is necessary to accomplish results. While many rotations may be executed during only one or two contractions, it may be necessary to persist for as many as five or six contractions. The prevention of maternal trauma by this method is well worth the extra time required. The undesirable feature of displacing the head upward by other methods of manual rotations is not encountered with this maneuver.

One gravida IV was taken to the delivery room prematurely. The cervix was found to be six centimeters dilated, with a right occiput posterior. Rotation was done, but the cervix was rather rigid so the patient was returned to her bed. The position remained ROA and in one hour she was completely dilated, and delivered spontaneously. This case is cited to bring out one point. No trauma was done to the patient by this method of rotation. Neither had I committed myself to immediate delivery.

In a number of patients rotation was carried out at eight centimeters dilatation, and in multiparas particularly it was found that rotation of the head was all that was needed for descent and delivery with the next few contractions. My practice is to allow spontaneous delivery if rotation is done before complete dilatation, then I am sure that further dilatation of the cervix is accomplished by natural forces, and not lacerated by forceps.

This is not an effective method for rotation of a transverse arrest. Poor flexion of the head appears to be responsible for this situation. By the same token, some poorly flexed heads may not be rotated beyond the transverse by finger rotation. This accounts for the 12 patients in

Continued on Page 906

Preleukemia: An Unusual Case of Nine Years Duration*

Will W. Ward, Jr., M.D.**
Louisville, Ky.

A case is described of persistent leukopenia of nearly nine years duration before changes diagnostic of acute myelogenous leukemia became manifest. The difficulty of distinguishing the preleukemic state from other hematologic disorders is emphasized.

PRELEUKEMIA refers to the disease state in which various hematologic abnormalities may exist prior to the occurrence of the diagnostic changes of leukemia.[1] The preleukemic state is therefore of necessity a diagnosis made in retrospect. Despite the fact that intensive investigation gives no evidence of the presence of leukemia until late in its course, it would seem logical to consider the earlier phase of hematologic abnormalities a part of the natural history of leukemia. Early hematologic changes may be quite non-specific and atypical. These consist of various combinations of anemia, leukopenia, neutropenia, and thrombocytopenia, with a normal or hyperactive bone marrow.[2] The diagnostic spectrum suggested by these findings includes hypersplenism, myeloid metaplasia, aplastic anemia, splenic neutropenia, splenic pancytopenia, leukemoid reaction, primary refractory anemia, and thrombocytopenic purpura.[3]

In all reported cases the preleukemic period has been characterized by evidence of deficiency in at least one aspect of hematopoiesis, and usually there has been some evidence of an abnormal hemorrhagic tendency fairly early in the course of the illness. The length of the preleukemic phase before the diagnosis of leukemia could be firmly established has ranged from a few weeks to thirty-nine months[4] and in one instance almost nine years.[5] The case discussed here presented initially as a leukopenia of unexplained etiology and ran a preleukemic course of almost nine years. The time interval from the definite diagnosis of myelogenous leukemia until death was only six months.

Case Report

E. C., a 46-year-old laborer, was admitted to the hospital on May 22, 1962 for investigation of an unexplained anemia which had caused exertional dyspnea and fatigue for approximately three months. He had previously been hospitalized for nine months in 1943 and 1944 for gun shot wounds of the leg incurred in North Africa. In May 1953 cough and chest pain led to a chest x-ray showing infiltration in the right apex and a right pleural effusion. On June 26, 1953 he was admitted to a state tuberculosis hospital where the diagnosis of moderately advanced tuberculosis was made and therapy with streptomycin and para-aminosalicylic acid was instituted.

On June 30, 1953 a complete blood count revealed a hemoglobin of 11 gm. per 100 ml., a white-cell count of 4,800 with an entirely normal differential, and a red-cell count of 3,520,000. On September 14, 1953 the patient was transferred to the Veterans Administration Hospital at which time a blood count revealed a hemoglobin of 12.4 mg. per 100 ml., a red-cell count of 4,900,000, and a white-cell count of 7,800 with a normal differential. The next blood count was obtained on October 19, 1953 and revealed a white-cell count of 2,300 with no other detectable abnormalities. The patient maintained a persistent leukopenia from this time until his death on January 10, 1963.

Numerous studies were done to elucidate the cause of the leukopenia. Anti-tuberculosis chemotherapy was discontinued on November 23, 1953 and not reinstituted during hospitalization which continued until May 21, 1954. Repeated blood counts during this period of

* *From the Department of Medicine, Norton Memorial Infirmary, Louisville, Kentucky*
** *Instructor in Medicine, University of Louisville School of Medicine*

hospitalization constantly showed a leukopenia of from 1,400 to 2,700 white cells with entirely normal differential counts and no abnormal cells. On November 9, 1953 a bone marrow examination was performed and showed no suggestion of abnormality. Culture of the marrow was negative for acid fast bacilli.

Studies during the remainder of hospitalization included repeated platelet counts, electrophoresis of serum proteins, serum iron and iron binding capacities, gastric analysis, x-rays of the gastro-intestinal tract, repeated reticulocyte counts, red cell fragility test, urobilinogen determinations, direct and indirect Coombs tests and coagulation tests. These were all normal. There was no response of the reticulocytes or white cells to rapid withdrawal of 500 ml. of blood. There had been marked improvement of the apical parenchymal abnormality and the pleural effusion had cleared when the patient was discharged from the hospital on May 21, 1954.

On March 20, 1957 a rather extensive laceration of the foot led to a brief period of hospitalization. At this time the hemoglobin was reported as 9.9 gm. per 100 ml., red-cell count 3,750,000, and white-cell count 2,150 with a normal differential. On February 2, 1958 a recurrence of fever and chest pain precipitated another hospitalization. Parenchymal abnormality in the right apex and a left pleural effusion were found at this time with a sputum culture positive for growth of acid-fast bacilli. On admission to the hospital the hemoglobin was 7.2 gm. per 100 ml., red-cell count 2,730,000, and white-cell count 1,150 again with an entirely normal differential. Bone marrow examination showed some increase in erythropoiesis and a maturation arrest of the myelocytic series at the band-cell level. The patient was given two transfusions of 500 ml. of whole blood each and transferred to the Veterans Administration Hospital where he remained until May 27, 1959. During this long period of hospitalization the white-cell count varied from 1,250 to 3,500. The differential count remained normal at all times and no abnormal cells could ever be found. Exhaustive studies were again performed without abnormal findings. Bone marrow examination on March 13, 1958 showed hyperplasia of the erythropoietic series and an increase in the number of mature eosinophils. The patient was discharged on March 27, 1959 and remained in reasonably good health until symptoms required the present hospital admission.

On admission to the Norton Memorial Infirmary on May 22, 1962 there were no abnormal physical findings aside from pallor of the skin and mucous membranes. There was no palpable lymphadenopathy and no organs could be felt within the abdomen. The initial blood count revealed a hemoglobin of 4.0 gm. per 100 ml. and white-cell count of 2,500 with a normal differential. Numerous hematologic studies were inconclusive. A bone marrow examination showed hyperplasia of both the erythrocytic and granulocytic series with a maturation arrest at the myelocytic stage. Since the patient had continued taking PAS and INH from the time of hospitalization in 1958 until this admission, it was felt one of these drugs might be the cause of the hematologic findings. He was transfused and advised to discontinue the drugs. The chest x-ray now showed only fibrocalcific changes in the apex.

Hospitalization was again required on July 17, 1962 because of the return of symptoms of anemia. The physical examination at this time again revealed only pallor without palpable lymph node or organ enlargement. The hemoglobin was 5.0 gm. per 100 ml. and white-cell count 8,675 with a large number of myelocytes and myeloblasts present in the peripheral blood. Bone marrow examination now showed almost total replacement with myeloid elements of the myeloblastic phase and was considered typical of acute myelogenous leukemia. Repeated hospitalizations were necessary for transfusions and regulation of chemotherapy from this time until the patient's death on January 10, 1963.

At autopsy the findings were those of a generalized hemorrhagic tendency with petechiae and ecchymoses over the entire body. There had been generalized bleeding from the gastrointestinal tract. The liver weighed 3,000 gms. and the spleen 1,000 gms. There was leukemic infiltration of the lungs, adrenal glands, pancreas, and spleen.

Discussion

This report describes the existence of a constant leukopenia in an adult for almost nine years before the occurrence of the diagnostic hematologic changes of acute myelogenous leukemia and emphasizes the prolonged period during which abnormal hematologic findings

may be present before the true nature of the disorder is revealed. The change from normal to abnormal in the peripheral blood occurred sometime during a one-month period and persisted throughout the course of the illness. Bone marrow examination following demonstration of this abnormality was normal in all respects. Bone marrow examination will usually differentiate the leukemic process from other disease states but on occasion atypical clinical and laboratory manifestations may precede recognizable leukemia by several years.[1] It must be emphasized that during this state of preleukemia all attempts at diagnosis failed to establish the true nature of the disease. This situation differs from that atypical variety of acute leukemia wherein symptoms may persist in a low-grade or smoldering fashion for a period of months or years before death occurs from another cause or from a more typical acute phase of the leukemia.[6] Here the diagnosis can be made by careful evaluation of the marrow at the time the patient is initially evaluated.

In cases of subacute leukemia very careful studies may not provide a clear-cut diagnosis until a near-terminal state has been reached, although the clinical course, signs, and symptoms may be very suggestive of leukemia.[7] Even histologic examination of the spleen may fail to predict the subsequent development of leukemia in patients with pancytopenia and hyperactive marrow.[2] The preleukemic phase has not been reported to precede lymphoblastic leukemia and practically all cases have subsequently been classified as myeloblastic or monocytic.[4]

As in other cases, many diverse disease processes were considered while trying to establish the true diagnosis during the preleukemic state in this patient. When anemia has preceded other hematologic or clinical evidence of leukemia, it has been suggested that some dyshematopoietic agent was responsible for both conditions.[8] Drug toxicity seemed a reasonable explanation late in the course of this patient's illness. Aplastic anemia[9, 10] and myeloid metaplasia[11] have been particularly difficult to differentiate from the leukemic state. The initial marrow abnormality reported in this case seemed quite in keeping with the histologic sequence of events seen during suppression of the marrow or the acute toxic neutropenia produced by drugs.

Because the diagnosis of acute leukemia still carries a very poor prognosis and is thought of as a rapidly and uniformly fatal disease, methods have been sought to prove or exclude this diagnosis. A blast-cell count in the marrow greater than six per-cent has been said to constitute strong evidence for the diagnosis of leukemia.[12] Application of this criterion would not have helped establish the subsequent diagnosis in the case reported here. In the preleukemic phase it has not been possible to establish the subsequent diagnosis in any manner. Palpable enlargement of lymph nodes, liver, and spleen has been delayed until the true leukemic phase has been reached. Previously reported marrow changes have followed a general pattern of hypoplasia with maturation arrest to hyperplasia with maturation arrest of the granulocytic series to an overwhelming of the marrow with immature cells.[1]

The terminal period has been brief when compared with the preleukemic period and therapy has been generally disappointing. Though the natural history of acute leukemic in adults may differ significantly from the commonly accepted picture[13] this case is unusual in the extreme length of the preleukemic phase. Despite the present lack of a uniformly successful therapeutic agent, prolonged remission and survival in acute leukemia is possible,[14] and it would therefore seem desirable to establish the diagnosis as early as possible. Awareness of the possible existence of a prolonged preleukemic phase would then stimulate more accurate diagnosis and the search for more effective therapy.

Summary

A case of acute leukemia in an adult is reported in which distinct hematologic abnormality persisted for almost nine years before the diagnosis of leukemia could be made. The initial abnormality was an unexplained leukopenia. Exhaustive study could not elicit the cause of the leukopenia or reveal the true identity of the disease. Moderate pancytopenia developed following the leukopenia and subsequently typical changes of acute myeloblastic leukemia occurred late in the illness. Despite all attempts during this exceptionally long period the diagnosis remained obscure until the terminal phase. Further studies of patients during the early phase of hematologic abnormality should add to our knowledge of the leukemic process.

References

1. Block, M., Jacobson, L. O., and Bethard, W. F. *Preleukemic acute human leukemia.* J. A. M. A. 152: 1018 — 1028, 1953.

Continued on Page 907

Selective Gastric Vagotomy*

Gordon L. Hyde, M.D., and David A. Hull, M.D.**
Lexington, Ky.

Selective gastric vagotomy is a safe effective method for ablating the cephalic phase of gastric secretion. The rationale, anatomy, operative procedure and early superior results are discussed.

SELECTIVE vagotomy is the operative procedure in which complete gastric vagotomy is accomplished, at the same time preserving the vagal innervation to the liver, biliary tract, pancreas, small bowel and one-half the colon. Because of the increasing awareness of the symptom complex described as the post-vagotomy syndrome, this procedure has been proposed. It is the purpose of this paper to discuss the rationale, operative approach and the results of this procedure.

Selective gastric vagotomy was first proposed and performed in the late 1940s by Richard Jackson, M.D.,[1] now in practice in Danville, Kentucky. However, in that era of enthusiasm for extensive resection, selective vagotomy was not fully evaluated and, in fact, total vagotomy was not accepted by most centers throughout the country. However, because of increasing awareness and the greater understanding of gastric physiology, it has recently achieved a new interest and enthusiasm. Burge, in England,[2] Griffith and Harkins,[3] Kraft and Fry,[4] in this country, have re-evaluated and renewed the interest in this procedure in the hope of decreasing post-vagotomy symptoms.

Post-Vagotomy Symptoms

Post-vagotomy symptoms are vague and ill defined and not unlike those described as the Dumping Syndrome.

The symptoms are vague abdominal discomfort, recurrent episodes of abdominal distention and bloating, with intermittent episodes of borborygmi and are present in 20 to 30% of post-vagotomy patients carefully evaluated. The last and most troublesome symptom is post-vagotomy diarrhea, which varies in severity from one to two watery bowel movements per day, to as many as 15 per day. It is generally mild and does not require much care, particularly in those who had severe ulcer symptoms before surgery and accept these symptoms as minor in comparison. The diarrhea typically occurs in intermittent episodes for a few days each month and rapidly subsides. However, occasionally this is severe and permanently disabling.

Many have estimated this complication to be present in from 18 to 30% of patients following total vagotomy, with severe symptoms in 5%. Some have attributed this to hypo-acidity with secondary bacterial contamination, but careful investigative studies have not substantiated this thesis. Others have thought that gastric stasis with decomposition of food explained the entity, but again studies have refuted this and these patients generally have adequate emptying procedures by all the usual criteria.

What is the cause of the other post-vagotomy symptoms? Biliary stasis has been proposed, as it is known that gastric stasis occurs after para-sympathetic de-innervation and the analogy of biliary stasis has been proposed. Johnson and Boyden,[5] after previously revealing that the gall bladder was primarily under hormonal control, demonstrated the fasting volume of the gall bladder increased considerably, approximately doubling in size following vagotomy, as well as demonstrating an increase in the size of the common bile duct. Furthermore, the contractility of the gall bladder is very sluggish and slow to respond following vagotomy. Is it not possible that long term stasis in the biliary tract could lead to an increasing incidence of cholecystitis and cholelithiasis? We are evaluating this question at the present time and, although definite statistical evidence has not been accumulated to support this assumption, our early impression is that

* *Presented at State Meeting of American College of Surgeons, March 29, 1963, Louisville, Ky.*
** *From the Department of Surgery, University of Kentucky Medical School, St. Joseph Hospital, Central Baptist Hospital and Good Samaritan Hospital, Lexington, Kentucky.*

there is an increased incidence of gall bladder disease following vagotomy.

Griffith and Stavney[3] reported that vagal denervation of the small bowel resulted in stasis. They demonstrated that stimulation of thoracic vagi in dogs induced contraction of the small bowel and this contraction remained after selective vagotomy but was greatly diminished after total vagotomy or division of the posterior branch of the vagus nerve.

Wright[6] demonstrated a cephalic phase of secretion of the succus-entericus and possibly alternations in the secretions of the small bowel may explain some of these symptoms. Pancreatic insufficiency, occurring following vagal denervation of the pancreas, may be responsible for the diarrhea. Pfeffer[7] demonstrated in patients, pre and post-vagotomy, that maximum stimulation with insulin hypoglycemia and secretion resulted in a total decrease in amylase output of the pancreas of 337% after vagotomy. McGee[8] presented further supportive work, under controlled conditions, in which partial pancreatic fistuli were created and dogs were studied pre and post-vagotomy. In the post-vagotomy phase they showed a 50% decrease in pancreatic output. Histologic studies of the vagus nerves reveal that 90% of the fibers in the vagus nerve are afferent while only 10% are efferent. So would it not be possible for many of the afferent fibers coming from the pancreas to elicit reflexes that might result in secondary hormonal alterations in gastro-intestinal physiology? This is an unanswered question. Thus, there is a rational physiologic basis on which to explain most of the post-vagotomy symptoms and the evidence is quite good that total vagotomy certainly produces physiologic abnormalities in the biliary tract, small bowel and pancreas.

Anatomy

The operative procedure, with proper exposure, is not difficult. A good understanding of the anatomy of the vagus nerve is essential to the procedure. Although there are multiple anomalies in the vagus nerve division and distribution above the diaphragm the present remarks will be confined to those abnormalities occurring below the diaphragm. In general, the anterior branch comes through the diaphragm to the cardiac portion of the stomach, giving off small esophageal branches and then cardiac branches on down to the stomach. (Figure 1)

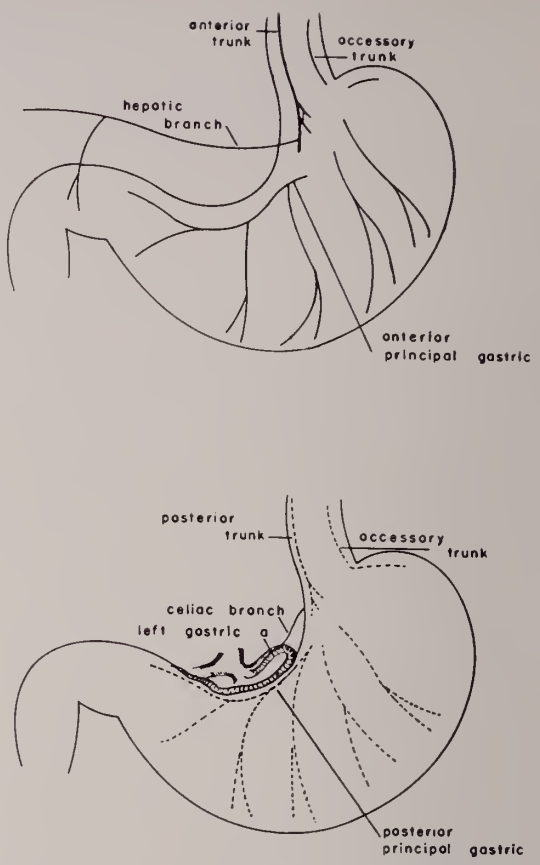


Figure 1.

The hepatic branch is separate, extending over to the porta hepatis and gives off a small branch down to the pylorus. The posterior branch also comes down to the cardiac position of the stomach, giving off its esophageal and gastric branches and extends down to the left gastric artery. At the level of the left gastric artery, it passes along it to the celiax axis, giving off the celiac branch of the vagus. By dividing all the smaller branches of the anterior vagus, preserving the hepatic branch, and severing all the branches of the posterior vagus but preserving the celiac branch, there will be no residual vagal fibers going to the stomach. This has been proven, not only in anatomic studies but in the clinical course of patients who have had selective vagotomy, as well as in multiple experimental studies on animals in which the vagus distribution is similar. As far as can be demonstrated, there are no vagal fibers coming back from the celiac plexus to innervate the stomach.

The operation for performing selective gastric vagotomy is thus devised for adequate exposure of the esophageal hiatus and once this has been obtained, it is no more difficult than dissection

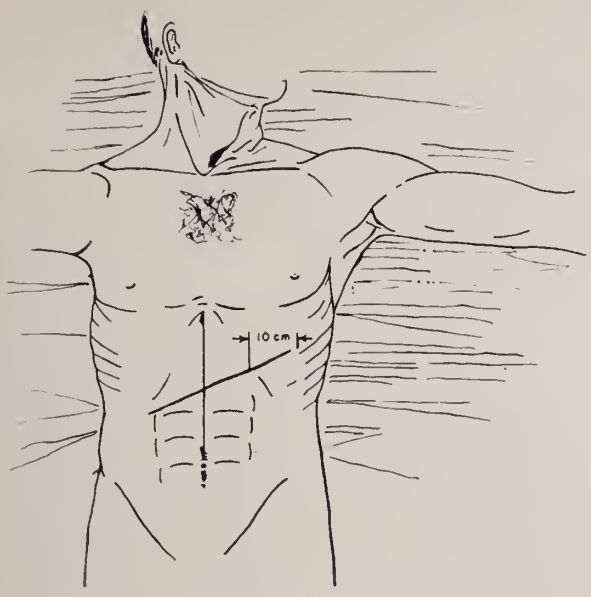


Figure 2.

of the recurrent laryngeal nerves. The incision used is a right subcostal incision extending well up over the left chest wall as recently described by Kraft and Fry[9]. (Figure 2) By carrying it well over the chest wall anteriorly and posteriorly beneath the costochondral junction, considerably more exposure of esophageal hiatus is obtained. Once this has been accomplished, the stomach is placed on tension, drawn caudally and to the left, placing the lesser omentum on tension. In this manner the hepatic branch of the anterior vagus can usually be visualized and easily palpated. The hepatic branch is then preserved and the gastric branches quickly and easily incised completely, freeing the anterior branch. The posterior branch is then identified and is followed down to the left gastric artery dividing all the gastric branches from it going to the stomach. From the left gastric artery it is followed to the celiac axis. Once this procedure has been followed, one can feel with assurance that a complete gastric vagotomy has been obtained. There are no known vagal pathways, by either anatomical or experimental studies, as previously stated, which suggest that vagal innervation can occur retrograde from the celiac axis. Thus, this is an anatomically feasible procedure, which can be performed with proper exposure but requires a complete knowledge of the anatomy of the region.

Results

The results of this procedure have been uniformly good.[2, 3, 4] The 12-hour overnight gastric acid studies, post-operative body weights, morbidity and mortality are the same, or better than those of total vagotomy.

Post-operative Hollander studies have been positive in approximately 5% in contrast to 12-25% following reported series of total vagotomy. It is felt by those utilizing this technique that the increased incidence of achlorhydria following selective vagotomy is due to better exposure and careful identification of all vagal fibers going to the stomach. A surprising but encouraging result has been that a better gastric vagotomy has been performed by the selective technique. The magnitude of the operative procedure has averaged 12 minutes more.

The duodenal content measured in response to insulin hypoglycemia pre and post-operative shows a reduction in amylase and bicarbonate concentration following total vagotomy but with no significant decrease after selective vagotomy. The incidence of diarrhea is definitely decreased.

In the past two years we have done this operation on 17 patients. They all have had negative 12 hour post-operative overnight gastric acid secretions and all are asymptomatic except for one with a mild, typical "Dumping Syndrome."

That the procedure is safe and effective no longer remains a question but further careful follow-up is necessary to establish its final role in the treatment of ulcer disease.

Summary

1. The post vagotomy syndrome is one of vague abdominal discomfort, recurrent episodes of abdominal distention and bloating, intermittent episodes of borborygmi and diarrhea.

2. Selective gastric vagotomy is a safe effective method for interrupting the vagal innervation to the stomach.

3. The rationale of selective vagotomy has been discussed with attention to the poorly understood physiologic alterations following vagotomy.

4. Reduction in post-vagotomy symptoms is becoming apparent as experience increases with this technique.

Bibliography

1. Jackson, R. G.: *Anatomic Study of the Vagus Nerves with a Technique of Trans-abdominal Selective Gastric Vagus Resection,* Arch. Surg. 57:333 (Aug.) 1948.

Continued on Page 907

The Role and Contributions of a State Mental Health Department to Community Mental Health*

Dale H. Farabee. M.D.**
Frankfort, Ky.

A review of the philosophy and organization of the Kentucky Department of Mental Health with respect to community mental health.

LADIES and gentlemen, distinguished physicians and members of the Kentucky State Medical Association, it is a distinct honor and pleasure to be here this afternoon to present this short inventory of the role and contributions of the State Department of Mental Health to community mental health.

We all know how far we have come in recent years in the treatment of mental and emotional disorders. We are all aware of the extremely high incidence of such disorders. Medicine as a whole, and psychiatry as a part of medicine, has found it increasingly difficult to supply even remotely adequate service to meet this demand. The supply and demand problem is seemingly without end, and as we improve treatment and facilities, the successes produced generate hope and more demand in others. Throughout the United States, the departments of mental health are finding this situation to be only too true. As of this date, there is no community of any size, or organization in the United States which has an adequate supply of psychiatric care in terms of both quality and quantity.

Three Services

The departments of mental health in the United States were created to meet a need of the people. Many years ago, this need of the general public was expressed as protection for and from mentally ill persons. People wanted not to accept emotional disorders as a fact, and their fears and everyone's general ignorance of the nature and causes of mental difficulties led to this denial. At any rate, most state departments of mental health were primarily organized for the purpose of custodial care. Little money or attention was given to the role of investigator or promoter of better mental health. But as we have noted, the role of mental health departments is changing rapidly. These departments must supplement and support private and local facilities. They never can and never have supplanted local and private facilities. They are not intended to do so.

The Department of Mental Health in this State, for instance, has organized itself to provide three distinct but inter-related services to the people of the State. The Department still basically fulfills the role of caretaker for many, but we now seek to provide services in other ways.

The first service is through the provision of hospital facilities for patients who cannot avail themselves of private treatment—whether it be on the basis of economics or non-availability of such private treatment.

Secondly, the department seeks to provide direct and indirect service at the local level through therapy, consultation, information and education. Third, the Department attempts to add to the general knowledge of the problems through study of the situations with which it deals.

On the community level, many state departments have a separate division of community service, which is non-hospital based. Such a division was established by Kentucky in 1952, and is designed to provide service to communities. The philosophy has been to help the community anticipate its needs in mental health and to aid them in securing and utilizing facilities.

Almost as soon as the first community mental health center was established in this State, it became apparent that the needs would overwhelm any possible direct therapeutic services that

---

* *Presented September 24, 1963 at Lexington during the KSMA Annual Meeting.*

** *Regional psychiatrist, Eastern Kentucky, Kentucky Department of Mental Health*

might be offered. In a kind of "agonizing reappraisal" the concept of individual case work had to be changed to the concept that in the communities mental health education would take precedence, and that each community would have to recognize its own needs and endeavor to meet them. With this in mind, the indirect therapeutic service was initiated and is being carried out as extensively as the limited personnel and finances of the Department will allow.

Organization

The Community Services Division provides such service to the state in four basic regions: Western Kentucky, the Louisville Area, Northern and Eastern Kentucky. This division recognizes that the objectives, services and methods of one area are not necessarily the most appropriate in another, and that individual communities have individual health and welfare problems and resources.

Each of these regions has at least one psychiatrist who gives consultation and advice to both professional and lay groups as it may be requested. Within this doctor's limits of time and area coverage, he sees as many patients as possible. Many Social Security and Public Assistance evaluations are made in this manner. Referrals from local physicians, school boards and public health nurses are seen and the patients returned to their supervision.

But beyond direct patient contact is the broad program contribution to community mental health. Basically, it is designed to provide services which will promote positive, or preventive, mental health practices. This program affirms the basic medical tradition of the United States that the individual, his family, or his immediate community should provide treatment services—not the government.

In some eighteen communities throughout the State, there are now located some part time consultative and/or treatment centers. Many of these consist only of a trained psychiatric social worker residing in the community and visited by a regional psychiatrist on a regular schedule. Others are only visiting clinics. But in those communities, the psychiatrist, social worker, and other Department personnel are actively giving casework service, resource contacts, public education and information, training and coordination. They cooperate with people from many other departments, organizations and groups in the establishment of workshops, visiting lecturers, consultation, and mass media distribution of information. Community Services personnel work with private and public health physicians, courts, ministers, schools, social agency staffs and the colleges and universities as well as our schools of medicine. They seek to teach positive mental health in order to prevent mental and emotional disorders as well as to give help for that which already exists.

Diagnostic and referral help is given whenever possible, and stimulation of citizen action groups such as mental health associations, mental retardation associations, etc., to provide organization and funds for further services is an important part of the program. Community Services' sibling unit, the Division of Mental Retardation, is working in identical fashion to provide similar services for mentally retarded persons. Two institutions are operative now for in-patient care and training.

This unit does not establish separate centers, but coordinates its community efforts closely with the established centers.

In eastern Kentucky, the community mental health centers are established at Lexington, Ashland and Somerset. To date, these centers are only beginning to get public support and have been entirely supported by State funds. In Western and Northern Kentucky, the centers are older and are partly supported by civic action. Many of them are counseled by advisory boards drawn from the local Mental Health Associations.

Louisville, of course, has a wealth of available coordinating agencies and is supported by both local and State funds.

In all the regions, the resident personnel and communities are aided by visiting teams of specialists in psychiatric nursing and school mental health consultation. These highly trained nurses and consultants coordinate their efforts with the local department personnel to arrange workshops, films, lectures and conferences for professional people having to deal with mental health problems and similar programs for lay persons. Educational television programs dealing with mental health will soon be seen statewide.

Still another community service is provided by the hospitals themselves. On a periodic basis, traveling teams of physicians visit regular posts to provide follow-up care for patients who have

returned to their homes from the hospitals. Day-care facilities at the hospitals will also be available soon.

Psychologists of all divisions of the state department attempt to help communities with evaluation of their candidates for special education classes. Consultant psychiatrists and psychologists from other areas are hired whenever they and funds are simultaneously available, and they fill in the gaps in our organization. Many state-wide meetings and conferences have been held with interested persons with regard to stimulating local participation and interest in the development of more adequate resources. County medical societies are involved as much as possible through the regional psychiatrist and their help to resident social workers has been invaluable.

In the future, it is hoped that matching federal-local funds plans will provide the cornerstone for really great progress in community mental health efforts and the Department of Mental Health will be ready and waiting to contribute any time, skill, and energy it may have available.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

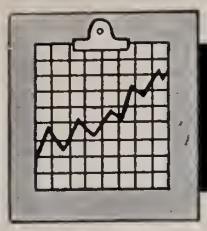
Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

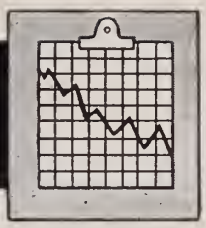
Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.



CASE DISCUSSIONS
From The
University of Louisville Hospitals



Eclampsia: A Case Report

JOHN L. DUHRING, M.D.* AND DONALD EDGER, M.D.*

THE exact incidence of eclampsia in the United States today is essentially unknown, but with improving prenatal care the incidence is certainly declining. However, most obstetricians would agree that even under optimal conditions an occasional sporatic case will be seen. In its role as a referral center, the University of Kentucky Medical Center's Obstetrical Department has seen many complications of pregnancy including eclampsia. The following case is presented because of its typical course and as an example of a regimen of management.

Mrs. D. B., a 17-year-old primagravida (EDC 10-2-63) was admitted to the University of Kentucky Medical Center at 4:30 p.m., 9-26-63 in a semicomatose, agitated condition. She had initially consulted her family physician for prenatal care 7-4-63. At that time her weight was 141 lbs., and her blood pressure was 120/80. It was noted that she was doing well. She was then seen subsequently about every two weeks with blood pressures in the range of 140 to 160 systolic over 90 diastolic. She gained 31 pounds over the next 11 weeks with demonstrable edema despite oral and parenteral diuretics. However, albuminuria was never a prominent feature in her course.

When seen on 9-22-63, her weight was 172 lbs., and her blood pressure was 140/90. The cervix was found to be uneffaced and closed. She was to continue on oral diuretics and oral phenobarbital and told to return in two weeks or sooner if necessary.

Apparently the patient was living alone much of the time. However, relatives had seen her early on the morning of 9-26-63 and found her slightly confused but otherwise apparently normal. When they returned at noon, she was unconscious and taken to her family physician's office. He found her blood pressure to be 170/100 and he confirmed the comatose state, although no convulsions were observed. He administered 260 mgs. of pentobarbital and 1.0 gm. of magnesium sulfate parenterally. She was then transferred to the University of Kentucky Medical Center.

On admission it was established that the patient's husband had witnessed at least one convulsion three days prior to admission. When first seen, the patient was agitated and restless with a blood pressure of 160/110, marked hyperreflexia was noted and pitting edema extending from the lower extremities to the thoracic cage was present. Her temperature at this time was 100.4° by mouth and abdominal examination showed a term size fetus with a vertex presenting towards the pelvis. Because the patient's tachycardia in the range of about 140 to 160 per minute, it was impossible to be certain that fetal heart tones were heard at this time. On pelvic examination it was found that the cervix was 1 to 2 cm. dilated and 90% effaced with a vertex presenting at about −2 station. The patient had stridulous respiration and multiple fine rales were heard over both lung bases. Morphine sulfate 10 mgs. was given intravenously, and within a few minutes of admission she had a convulsion. This was controlled rapidly with intravenous amobarbital. Also given were:

Reserpine 5 mgs. 1M
Magnesium Sulfate 10 gm. 1M

Within two hours her blood pressure stabilized at about 120/80 but up to 100 mgs. of amobarbital were required intravenously every hour to control her restless, agitated state. Urinary output, as measured hourly, was the oliguric range (i.e., 0 to 20 cc. per hour). Proteinuria was a prominent feature of her hourly urine analysis running from 2+ to 4+ on a semiquantitative scale. Intravenous mannitol was used in 12.5 to 25 gm. amounts every six hours in an attempt to produce osmotic diuresia. Sixteen hours after admission vital signs were: BP 120/70, P 80, R 24, temp. 100.4° PO. On pelvic examination the cervix was found to be 3 cm. dilated, 80% effaced, with a vertex presenting.

At this time the patient was having irregular mild contractions every 4 to 10 minutes and lasting some 20 to 30 seconds. An amniotomy was performed with the release of deeply meconiumstained fluid. Labor then progressed satisfactorily. A continuous epidural anesthetic was begun, and intravenous oxytocin stimulation was added to the regimen.

After six-and-a-half hours it was possible to deliver a 6 lb. 4 oz. Apgar 3 living male child at 5:22 p.m. on September 27, 1963. The baby was initially depressed and required endotracheal intubation. In the immediate postpartum period the patient maintained normotensive pressures and alternated between coma and agitated delirium.

Approximately 24 hours after delivery her blood pressure began rising to a range of 130 to 160 systolic over 90 to 110 diastolic. Parenteral reserpine was continued in 2.5 mg. doses intramuscularly every six hours. Forty-eight hours after delivery the patient first awoke and could carry out a meaningful conversation with retention of facts presented.

From the department of obstetrics and gynecology, University of Kentucky Medical Center.

Over the next several days she continued hypertensive levels and the reserpine was stopped with no change in her blood pressure. Another facet of the problm was consistenly depressed serum potassium levels, even in the antepartum period when she was oliguric.[1] Accordingly an extensive search for other causes of hypertensoin was instituted, but the patient left the hospital against medical advice before much could be accomplished. Her weight loss from September 22, 1963 through October 6, 1963 was 36 pounds.

This case is typical in several respects, while some atypical aspects were never fully explained. Eclampsia is a fulminating disease occurring largely in primagravidas with limited or inadequate prenatal care. The vast majority of cases are preceded by the characteristic and well-defined changes of pre-eclampsia. The present day armamentarium of diet, drugs, and occasionally hospitalization will control the vast majority of pre-eclamptic patients. The established beneficial effect of salt restriction and/or oral diuretics of the thiazide type is well known. However, in situations such as the case presented, either due to the refractory nature of the disease or lack of patient cooperation, then hospitalization must be utilized if eclampsia is to be prevented.

Regardless of the antecedent factors, once convulsions and/or coma have occurred, hospitalization is mandatory. In this instance, however, there was at least a three day delay due to patient neglect. It is not uncommon for a lucid interval to develop following the initial coma even without therapy as did apparently occur with this patient. When the eclamptic patient is ultimately hospitalized, the definitive therapy is to terminate the pregnancy under such circumstances that will best favor the survival of the mother and baby. All too often the life of the fetus is forgotten or neglected in the face of grave concern for the mother. The maternal mortality in various large, well supervised series seems to be nearly constant. A return to early delivery of the infant has been suggested in order to improve fetal salvage.

All regimens of therapy should be based on the consideration of the basic pathophysiology of the disease. The most recent investigations in this area indicate the common lesion in all organ systems is endarteriol spasm.[2] However, the neural and/or humoral factors producing this vascular spasm have not yet been positively identified. Some experimental work recently reported seems to indicate a humoral factor circulating in the blood and obtainable from the placenta in cases of eclampsia.[3] The exact chemical nature of this substance, or substances, is not yet proven, but may be our first lead to the exact etiology of eclampsia.

The role of magnesium in controlling neuromuscular irritability is well known. Magnesium ions depress not only the central nervous system but the peripheral muscle irritability as well. It is important to note that a wide margin of safety is available in the parenteral use of magnesium. Magnesium levels of 3 to 6 mgs. per cent are considered therapeutically effective in eclampsia while deep tendon reflexes do not disappear until levels of approximately 10 mg. per cent are reached. Respiratory arrest will develop at 12 to 15 mg. per cent and soon thereafter cardiac arrest ensues. It is suggested that even in the face of oliguria, the initial dose of magnesium be 10 gms. (i.e. 20 cc of 50% solution magnesium sulfate). Generally, additional doses of 5 gms. can be given every six hours if deep tendon reflexes are still active. It should also be noted that intravenous administration of calcium solutions will reverse magnesium depression.

Reserpine has been found to be effective in controlling the vasospasm when given in relatively large doses (i.e. 2.5 to 10 mg. intramuscularly or intravenously). The aim of therapy is to reduce blood pressure by a factor of about 25%. This can be achieved in many cases with an initial dose of 2.5 to 5.0 mg. intramuscularly with subsequent doses of 2.5 to 5.0 mg. depending on the individual patient response. Hydralizine is sometimes necessary to control blood pressure when the reserpine response is unsatisfactory. This is best given as intravenous drip containing 60 to 100 mgs. of the drug per 1000 cc. of 5% dextrose in water. The rate of flow must be carefully titrated against the blood pressure as profound hypotension may be produced by this drug. Adequate sedation of the patient is achieved by parenteral administration of short acting barbiturates. However, since most barbituric acid derivatives are excreted through the kidneys, caution must be used in oliguric patients. It is recommended that urinary output be monitored hourly as measured from an indwelling catheter.

Since the kidney is ischemic, extreme caution must be observed in using any of the common diuretic agents. Preferably diuresis is to be encouraged by an osmotic agent such as hypertonic glucose solutions or mannitol. The general support and nursing care of these gravely ill women is of paramount importance. They should be under constant observation with facilities immediately at hand to treat airway obstruction and/or recurrent seizures. Also they should be in a darkened room as free as possible from extrinsic stimuli.

Even after delivery these patients are still gravely ill. They require as much care and attention as prior to delivery. Hypertension, coma, and/or convulsions may still be a problem as long as 48 hours after delivery. As a rule most eclampsia patients will begin to show marked improvement about the second postpartum day. This improvement is frequently first manifested as an increase in the level of consciousness. Blood pressure will begin to assume more normotensive levels, and a spontaneous diuresis will begin. During this phase of diuresis 10 to 12 liters of urine may be excreted per day. This rapid and dramatic fluid loss will, however, frequently severely alter serum electrolytes as fluid is lost on the one hand and mobilized from the extravascular spaces on the other. At these times careful attention must be paid to serum electrolytes, and occasionally supplementation must be given to correct dangerous imbalances.

In summary, the classic management of eclampsia has dictated some fixed, and rather arbitrary period free of convulsions prior to any attempt at effecting delivery. It now seems, however, that if fetal salvage is to be improved, decisive attempts at delivery must be instituted as soon as the mother's condition is sta-

bilized and it seems reasonable to except that she will safely tolerate labor or operative intervention. A wide variety of chemotherapeutic agents are now available to achieve control of the disease and our regimen has been briefly outlined.

Summary of Management for Eclampsia

I. General Measures
   a. Constant observation and frequent vital signs.
   b. Quite darkened room.
   c. Indwelling catheter and hourly urine measurements.
   d. Frequent and inclusive physician evaluation.
   e. Continuous intravenous drip 5% D/W.

II. Airway Protection
   Have immediately available:
   a. Oxygen
   b. Suction
   c. Oral and endotracheal airways
   d. Laryngoscope

III. Antihypertensive drugs
   a. Normotension—nothing
   b. 130-160/90-110: Reserpine 2.5 mg IM
      Repeat hourly until 25% reduction accomplished,
      Maintain desired level by 2.5 mg - 5.0 mg every 4 to 6 hours.
   c. Over 160/110: Reserpine 2.5 mg IM
      Hydralazine drip (as described)
      Maintain 25% reduction

IV. Diuretics
   a. Hypertonic dextrose solutions.
   b. Mannitol—12.5 to 50 gms. I.V. every six hours

V. Morphine sulfate to control pain and aggitation as described.

VI. Barbiturates—Short acting agents to sedate as described.

VII. THE CURE: Delivery under conditions to favor survival of mother and fetus.

Bibliography

1. Crane, M. G., Andes, J. P., Harris, J. J., and State, W. G., *"Primary Aldosteronism in Pregnancy"*, Obst. and Gyn., 23: 200, 1964.
2. Hopper, J., Hiroshi, Y., Moon, H. D., and Page, E. W., *"Renal Lesions in Pregnancy"* Obst. and Gyn., 17:271, 1961.
3. Tatum, H. J., and Mule, J. G., *"The Hypertensive Action Blood from Patients with Pre-eclampsia"*, Am. J. Obst. and Gyn., 83:1028, 1962.

You are urged to attend

the

AMA Winter Clinical Meeting

Miami Beach, Florida

November 29 - December 2



The Aims and Purposes of Medical Assistants*

Bettye J. Fisher**

Evansville, Ind.

IN OUR daydreams, we often receive tokens of esteem from unknown admirers. Today, gentlemen, I bring you verbal evidence of esteem for the members of the medical profession from a known admirer—myself, as a medical assistant—myself, as a member of the American Association of Medical Assistants. Let me tell you, too, of my esteem for the American Association of Medical Assistants.

Like yourselves, these women came together in a common bond, arising from common interests, a desire to share knowledge, to find more knowledge, to establish professional standards, and to face issues in which we have a common concern.

The common interests, the desire to share knowledge and to find more knowledge are all very familiar to you. Although you are well aware of your own professional standards, you may wonder what we mean by professional standards. Briefly stated, the basic objectives of the A.A.M.A. are: to inspire its members to render loyal, more efficient service to the profession and to the public which we serve, to cooperate with the medical profession in improving public relations, and to render educational services for our members. This Association, in its Constitution, declares that *it is not, nor shall it ever become a trade union or collective bargaining agency.*

Our Association is relatively young, but today I stand before you representing over 12,000 members of my Association, with active chapters in forty-one affiliated states, including Hawaii and Alaska, and with several sister chapters in Canada. One of my greatest privileges as president of A.A.M.A. was chartering the Kentucky State Association of Medical Assistants in 1962, with active chapters in Louisville, Frankfort, and Elizabethtown.

We are seeking advancement through self-education, the immediate reward being increased self-respect. Many of us for years yearned for some means of equipping ourselves to better serve you, and the facilities available scarce—in some instances nonexistent. So, with typical American, and I might say medical, ingenuity, we set out to do something about it. We established local organizations of medical assistants and invited persons knowledgeable in various fields to come instruct us in areas in which our knowledge was inadequate. This served to pique our interest—we couldn't learn fast enough this way, so with the encouragement of our state and national associations, we accelerated our programs through workshops, symposia, college and junior college courses.

Gentlemen, we share your real concern for the protection of the private enterprise system in the United States today. In 1961, as presiden tof A.A.M.A., I appeared before the House Ways and Means Committee in Washington, D.C., to testify on behalf of our members in opposition to the King-Anderson Bill. And I might add that our testimony was in direct conflict with that of the American Nursing Association who had testified in favor of this measure. Just a few months ago, our president, Mrs. Judy Coleman, and our immediate past-president, Miss Alice Bundy, appeared with Doctor Annis and Doctor Welch before this same Committee to reiterate our opposition to H.R. 3920,

Presented before the September 28 House of Delegates meeting of the Kentucky Medical Association during the 1964 Annual Meeting in Louisville.

**Mrs. Fisher is a past-president of the American Association of Medical Assistants and has been a frequent visitor to Kentucky in this connection.*

and any other form of socialized medicine. We feel privileged to stand and be counted with you—as persons with special knowledge—on such a vital issue.

Yes, we share your concern, and pledge our continuing support of protection of the people of the United States against further encroachment on the rights of the individual, and further removal of the incentive of private endeavor. Through efforts of a very active Legislative Committee, A.A.M.A. has the past few months made personal contact with each member. We have requested her to write her Congressman and we also suggested she give the "Boss" a gentle nudge and see that his letter was in the mail, too. In one small chapter of 35 members, I know that medical assistants were directly responsible for over 300 telegrams being sent to Washington to oppose socialized medicine.

The American Association of Medical Assistants has come a long way in its brief seven years . . . but it has not come alone. Along the way it has picked up support, the most cherished of which is the American Medical Association, whose members have asked us time and again, "How can we help further your cause and aims?" The answer is simple, gentlemen. If you believe in our purposes, if you believe that our 12,000 members, multiplied many-fold, could benefit you individually, and therefore, collectively—as the Kentucky State Medical Association—then we ask you: give us your help *Individually*. When you go back home, spread the word. Encourage the formation of a chapter in your county if there is none; encourage your medical assistants to join if there is one, and then work with them!

And, please, tell others that we are not, nor shall we ever become a trade union or collective bargaining agency. Just as you do not want a third party in the physician-patient relationship, we do not want a third party in our employer-employee relationship! Let me share with you a creed, which I feel typifies our feeling about protecting our share of that valuable American right . . . *free enterprise*:

> I do not choose to be a common man or woman;
> It is my right to be uncommon, if I can.
> I seek opportunity—not security.
> I do not wish to be a kept citizen, humble and dulled by having the state look after me.
> I want to make the calculated risk; to dream and to build; to fail and succeed.
> I refuse to barter incentive for a dole.
> I prefer the challenges of life to the guaranteed existence; the thrill of fulfillment to the stale calm of Utopia.
> I will not trade freedom for beneficence, nor my dignity for a handout.
> I will never cower before any master nor bend to any threat.
> It is my heritage to stand erect and proud and unafraid; to think and act for myself, enjoy the benefits of my creations and to face the world boldly and say,
> This, with God's help, I have done!
> All this is what it means to be an American.

And this is what it means to me to be a member of the American Association of Medical Assistants.

Won't you gentlemen help us . . . To help you?

The Southern Medical Association

58th Annual Meeting

will be held

November 16-19 in Memphis

Diabetes – An Old Enemy*

Robert Hendon, M.D.**
Louisville, Ky.

WHETHER you are a member or a guest I commend your interest in diabetes. Whether you are a specialist or generalist, a consideration of diabetes must obtrude itself into your work.

I believe we are beginning to learn something about this mysterious disorder called diabetes mellitus. We have left behind the old idea that all hyperglycemia is diabetes. We have learned that there are at least two, perhaps more, varities of the disease. We have drawn away from the view that the problem is merely one of not enough insulin.

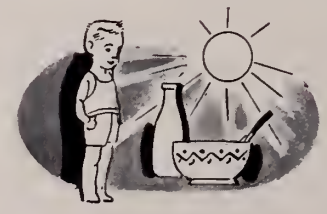
While the diagnosis of "pre-diabetes" can be made only in retrospect, we have found means to unmask latent diabetes, and so, in part, to learn the reason that the chronic complications of diabetes may be found some time before obvious carbohydrate intolerance.

We are currently considering the possibility that this carbohydrate intolerance may be a somewhat secondary manifestation—that the essential pathology centers elsewhere. At any rate, latest estimates suggest that there are in the neighborhood of 4,000,000 diabetics in the United States.

The facts are that the annual death rate from diabetes in this enlightened age is 16.4 per 100,000, placing it as the seventh most frequent cause of death. Although there may be some dispute concerning treatment, the weight of evidence indicates that good control of the diabetic state goes hand in hand with greater life expectancy.

In view of these considerations, the membership of the Kentucky Diabetes Association is dedicated to a quest for new information about the disorder, to the sharing of knowledge with colleagues anywhere, and to teaching recognition and control wherever we can. We are interested in the formation and the activities of the associations of laity concerned with diabetes. We are working toward the establishment of a summer camp in Kentucky for diabetic children.

We welcome the active participation of any and all physicians to these ends.



**Presented as the welcoming address to the Kentucky Diabetes Association at its annual meeting, held in Louisville September 28, 1964, in conjunction with the 1964 Annual Meeting of the Kentucky Medical Association.*

EDITORIALS

Everybody's Doin' It Now

IT DOES not add to a physician's happiness to feel that some of his colleagues are looking over his shoulder all of the time evaulating the thoroughness, completeness or quality of his work. It has come to pass in recent years, however, that this is the order of the day. It can probably be charged mostly to activities of hospital accreditation agencies that tissue committees, medical appraisal committees and insurance committees have come into being and are necessarily now part of the duty of every medical staff, if the hospital concerned is to maintain accreditation.

It may be some consolation to feel that while your colleagues are watching your work and referring your records back to you with various criticisms, that in the next year you may be doing exactly the same thing for them. It is not a desirable task and most of us would prefer to be on the receiving rather than on the giving end of this type of activity. It is, however, essential in the present day operation of hospitals and must be accepted with as much grace and equanimity as one can muster.

Much has been said in criticism, quite a bit of which is unjust, of the medical profession in recent years, but this has led to a more thorough-going effort to monitor our own conduct. County and state medical societies are more concerned with the professional conduct and the ethical standards of their members than with the minutiae concerned with their records. Various judicial or grievance committees seem to be an essential part of every organized body of physicians. These commitees are usually without disciplinary powers except upon a purely local level and effect no punitive action beyond reprimand and curtailment of hospital privileges or revoking of membership.

These methods of correction cannot be taken lightly. To interfere with or seriously handicap the physician's professional activity or pursuit of his livelihood is a very serious measure and should never be done except in the most extreme and intractable instances of misconduct.

Criticism or censure with regard to fees is a very ticklish function. Since there are no established schedules of fees for physicians and since almost every medical or surgical service is different in scope and time consumed and importance to one's health, it is a most difficult matter to appraise. If any committee concerned with this phase of practice is able to bring about harmony and understanding and agreement between the physician and his patient involved it is generally considered to have accomplished its purpose.

The more serious and persistent instances of misconduct or unprofessional practices which resist satisfactory settlement by local committees eventually may come to the attention of the State Board of Health which is in fact the ultimate or final court of judgement; this board alone is empowered to effect disciplinary action, the suspension or revocation of license, and the removal of a physician from practice.

Many physicians and a greater number of persons outside our profession become impatient and intolerant of the reluctance of the State Board of Health to pass final judgement on the physician and remove him from practice even when his conduct seems to richly deserve it. It must be remembered, however, that patience, and charity must govern the actions of this body.

The present State Board of Health is composed of physicians and some non-physician members. Preference has often been expressed that disciplinary action on physicians should be conducted by physicians only, and considerable thought has been given the establishment of a disciplinary board in the State Medical Association composed only of physicians to whom cases of unprofessional conduct would be referred for judgement. There is certainly reasonable merit to this proposal. To the present date it does not seem that the presence of non-physician members on the State Board of

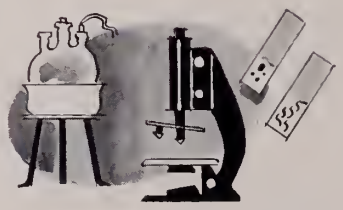
Health has seriously handicapped or curtailed its work, and that by and large over a long period of time this body has performed a creditable service to the profession. Certainly it may be improved and should, by one means or another, become more effective.

During the past two years the Medical Discipline Committee of KMA has given much thought to the creation of a Judicial Council composed of members of KMA with power to subpoena, hear testimony, judge inept medical practices as well as unethical conduct, and be able to enforce disciplinary action such as fines, expulsion from KMA and to recommend through the KMA Board of Trustees that the State Board of Health revoke the offending physician's license to practice medicine. The recommendation of this committee that a Judicial Council for the KMA be created was accepted and implemented at the 1964 meeting.

The question naturally arises whether all of this monitoring has borne good fruit and whether it is worth the time and generally unpleasant effort that it entails. Apparently it has and is. If minor infringements of professional and ethical conduct can be discerned and dealt with at the local level early before they become chronic habits, the physician himself may be saved, his professional career elevated and extended, and the health of the people protected. The more thorough this work is done locally and in its incipiency less often will serious instances of misconduct require more drastic action.

Certainly our hospital records are immeasurably better and the level of professional practice is greatly improved over that of a generation ago. This undoubtedly is due in part to the activities of the hospital accreditation boards and the committees above mentioned. Unquestionably the professional and ethical conduct of physicians in general is better now than it was 50 or 25 years ago. The growing awareness on the part of the profession of this need to correct our own abuses has operated to safeguard more securely the of the people we serve. The medical profession has perhaps led all others in such an effort.

SAM A. OVERSTREET, M.D.



Diabetes Week

AGAIN this year, as in previous years, years, the week preceding Thanksgiving has been designated as Diabetes Week. The Diabetes Detection Drive is a year-round effort to find unknown diabetics and guide them to medical care. The Drive as well as Diabetes Week is sponsored by the American Diabetes Association, founded by and composed of physicians. The Association works through 50 local affiliate Associations and through 900 Committees on Diabetes organized within the framework of State and County Medical Societies.

The year-round effort is featured by an annual nationwide Diabetes Week during which as many persons as possible are screened for diabetes. Last year 96,333 persons were screened for diabetes in the state of Kentucky. Although the exact number of new diabetics detected cannot be accurately ascertained, the number is believed to be in excess of 182. This year, it is hoped, even larger numbers of persons will be tested and more new diabetics discovered than in previous years.

Helping to detect diabetes is one way of giving better medical care to more people. About 3,400,000 Americans are diabetic but roughly half of these are "unknown"—that is their diabetes remains undiagnosed and therefore uncontrolled. Perhaps as many as 5,500,000 more are potential diabetics. On an average of one out of 135 patients that comes into a physicians office will be an unknown diabetic. Every physician wishing to improve the care of his patients will want to detect diabetes as early as possible in the people for whom he is medically responsible.

The postprandial blood sugar is the most effective screening test for diabetes. The Diabetes Committee suggests every physician do postprandial blood sugars on as many of his patients as possible during Diabetes Week, and try to test all patients once a year. Also the physician should tell them the importance of diabetes detection and advise them to have members of their families tested for glycosuria.

The physician may also help to improve statistics on the incidence of diabetes by reporting to the Committee the number of patients tested during Diabetes Week, the number showing glycosuria and the number of these determined to be true diabetics.

The Diabetes Detection Drive can succeed only with the cooperation of the practicing physician. He is the first and main line of detection, as he is the first and only line of treatment. His help is essential if unknown diabetics are to be brought under medical care and thus remain effective members of the community.

ROBERT S. TILLETT, M.D., Chairman
KSMA Committee on Diabetes

ORGANIZATION SECTION

Dr. Baker Chosen by Delegates As KMA President-Elect

Everett H. Baker, M.D., Louisville, was unanimously chosen president-elect of the Kentucky Medical Association at the second session of the House of Delegates in Louisville on September 30.



Dr. Baker

Installed as president was Delmas M. Clardy, M.D., Hopkinsville, who succeeded George P. Archer, M.D., Prestonsburg, in that office.

Doctor Baker, a native Louisvillian, completed his undergraduate work at Vanderbilt University and graduated from the University of Louisville School of Medicine in 1925. A veteran of the USAF, he served during World War II finishing his tour of duty as a Lieutenant Colonel.

Assistant professor of anesthesiology at the University of Louisville since 1947, Doctor Baker became a diplomate of the American College of Anesthesia in 1948. He is a former vice president of KMA (1955-6), a past president of the Jefferson County Medical Society, the Kentucky Society of Anesthesiologists, the Louisville Society of Anesthesiologists, and the Innominate Society. Doctor Baker is presently on the Board of Directors of Kentucky Physicians Mutual.

Newly elected vice presidents are: Robert Lykins, M.D., Louisville, Central; Harold Barton, M.D., Corbin, Eastern; and Kenneth M. Eblen, M.D., Henderson, Western.

J. Thomas Giannini, M.D., Louisville, was re-elected AMA delegate and Charles G. Bryant, M.D., Louisville, was voted another term as alternate delegate to the AMA.

Dr. Quertermous in AMA Post

John C. Quertermous, M.D., Murray, KMA Delegate to the American Medical Association, has been named to serve on a reference committee at the winter clinical meeting of the AMA in Miami November 29-December 1.

Milford O. Rouse, M.D., Dallas, speaker of the AMA House of Delegates, has appointed Doctor Quertermous to serve on the Reference Committee on Legislation and Public Relations.



Delmas M. Clardy, M.D., Hopkinsville, (left) takes the oath of office as new KMA president at the second meeting of the House on September 30. Administering the oath is Douglas E. Scott, M.D., Lexington, chairman of the Board of Trustees.

Drs. Pennington and Chatham to Lead Board of Trustees

Robert E. Pennington, M.D., London, who served KMA as a vice president (Eastern) in 1961-2, was elected chairman of the Board of Trustees at a meeting of the Board in Louisville during the Annual Meeting on October 1. Donald Chatham, M. D., was elected vice chairman.



Dr. Pennington

Doctor Pennington succeeds Douglas E. Scott, M.D., Lexington, as chairman. Active in KMA activities for many years, Doctor Pennington represents the fifteenth district on the Board. He has been secretary of the Laurel County Medical Society and is a member of the American College of Surgeons.

Doctor Chatham, a past president of the Shelby-Oldham-Henry Medical Society, succeeds Gabe A. Payne, Jr., Hopkinsville, as vice chairman.

Newly elected trustees include: W. Gerald Edds, M.D., Calhoun, who succeeds Howell J. Davis, M.D., Owensboro, second district; and Walter L. Cawood, M.D., Ashland, who succeeds Clyde C. Sparks, M.D., Ashland, in the thirteenth district.

Re-elected as trustees were: Donald Chatham, M. D., Shelbyville, seventh district; Mitchel B. Denham, M.D., Maysville, ninth district; Douglas E. Scott, M. D., Lexington, tenth district.

KMA Members Planning to Attend AMA's Miami Beach Meeting

A number of KMA members have made plans to go South for the American Medical Association's 18th Clinical Convention in Miami Beach on November 29-December 2.

KMA Delegates to the AMA—Wyatt Norvell, M.D., New Castle; J. Thomas Giannini, M.D., Louisville; and John C. Quertermous, M.D., Murray—will be among those making the Florida trip. Also planning to attend are Alternate Delegates—Charles G. Bryant, M.D., Louisville; William W. Hall, M.D., Owensboro, and Charles C. Rutledge, M.D., Hazard. Delmas M. Clardy, M.D., Hopkinsville, KMA president, will also be among those attending.

Timely subjects of wide interest will be discussed at the scientific sessions which will be followed by question and answer periods. A comprehensive series of lectures in the obstetrical field will be a highlight of the scientific program. Another important feature of the program will be a series of eight lectures on vascular occlusive diseases on the final day of the meeting. Other major areas to be covered are immunization, depression, cardiac arrhythmias, emphysema, iatrogenic diseases and hypertension.

The entire scientific program, with the exception of fireside conferences, will be held at the Miami Beach Convention Hall. On display will be 125 scientific exhibits, including a special exhibit on fractures.

More than 300 physicians will participate in a full program of lectures, exhibits, motion pictures, color television, fireside conferences and breakfast roundtables.

Nominating Committee Named

A five man nominating committee to select a slate of KMA General officers for 1965 was chosen by the Association's House of Delegates on September 30.

The nominating committee will hold its first meeting at the KMA Interim Meeting in Owensboro on March 18. At that time a chairman will be elected. Members of the committee are: Harold B. Barton, M.D., Corbin; Carl H. Fortune, M.D., Lexington; Russell L. Hall, M.D., Prestonsburg; James M. Riley, Jr., M.D., Louisville; and Paul J. Sides, M.D., Lancaster.

Two Ky. M.D.s in ATS Posts

William H. Anderson, M.D., associate professor of medicine and director of the Pulmonary Center at U. of L., and Kurt W. Deuschle, M.D., professor and chairman of the department of community medicine at U. of K., have been named to committees of the American Thoracic Society.

Doctor Deuschle has been elected to the editorial board of the society's publication, *The American Review of Respiratory Diseases.* Doctor Anderson will serve on the committee on medical education and was also elected to a second term on the society's governing board.



Leaders of the Woman's Auxiliary to KMA talk with the President-Elect of the Woman's Auxiliary to the AMA during the Annual Session. From left to right—Mrs. Richard Sutter, St. Louis, AMA Auxiliary, president-elect; Mrs. J. Jack Martin, Tompkinsville, president, KMA unit; Mrs. Robert J. Salisbury, Mt. Sterling, president-elect KMA auxiliary; and Mrs. J. Murray Kinsman, Louisville, KMA auxiliary immediate past president.

Mrs. Salisbury Chosen Pres.-Elect Of KMA Woman's Auxiliary

Mrs. Robert J. Salisbury, Mount Sterling, was chosen president-elect of the Woman's Auxiliary to the Kentucky Medical Association at the Auxiliary's Annual Convention held in Louisville in conjunction with the KMA Annual Meeting.

She will succeed Mrs. J. Jack Martin, Tompkinsville, who was installed as president for 1964-65. Outgoing president Mrs. J. Murray Kinsman, Louisville, presided at the 1964 meeting at the Kentucky Hotel.

Other new officers include: Mrs. Ballard Cassady, Pikeville, first vice president; Mrs. Charles Kissinger, Henderson, second vice president; Mrs. O. L. May, Danville, third vice president; Mrs. Robert A. Stewart, Ashland, fourth vice president; Mrs. James A. Harris, Paducah, recording secretary; and Mrs. William C. Durham, Louisville, this year's convention chairman, treasurer.

Ky. Diabetes Assoc. Elects

Robert Hendon, M.D., Louisville, presided at the third annual meeting of the Kentucky Diabetes Association in Louisville on September 28. William Winternitz, M.D., Lexington, was chosen president-elect at the association's business session. Other new officers are: Lewis Dickinson, M.D., Glasgow, vice president; Kenneth Crawford, M.D., Louisville, secretary; and Arthur T. Hurst, M.D., Louisville, treasurer.

Featured speaker was William R. Kirtley, M.D., who spoke on the "Newer Concepts of Insulin". Other speakers were Maurice Best, M.D., Kenneth Crawford, M.D., and Harold Kramer, M.D., all of Louisville, and John Selby, M.D., Lexington. The Jefferson County Lay Diabetes Association joined with the KDA at a lucheon where Doctor Kirtley spoke on "Oral Hypoglycemic Agents".



Faculty Scientific Achievements Awards were presented at the President's Luncheon at the Annual Meeting. At the left is John W. Brown, Ph.D., University of Louisville Medical School's chairman of curriculum, recipient of the U of L Award. At right is Dean William R. Willard of the University of Kentucky Medical Center who accepted the U of K award for Frank C. Spencer, M.D., Lexington, who was in California.

Drs. Brown, Spencer Honored With KMA Faculty Awards

John W. Brown, Ph.D., associate professor of biochemistry at the University of Louisville, and Frank C. Spencer, M.D., professor of surgery at the University of Kentucky, received the 1964 Kentucky Medical Association Faculty Scientific Awards at the President's Luncheon September 30 during the KMA Annual Meeting in Louisville. William R. Willard, M.D., Dean of the U. of K. College of Medicine, accepted the award for Doctor Spencer, who could not be present.

The awards, presented this year by William Bizot, M.D., Louisville, chairman of the KMA Awards Committee, were established in 1962 in order to recognize facultly members from Kentucky's two medical colleges for outstanding research or other significant contributions.

Doctor Spencer came to Lexington in 1961 from Johns Hopkins University School of Medicine. Before the University of Kentucky Hospital opened, he was engaged in research which set the stage for later clinical experimental triumphs. He was recognized for his achievements in the field of open-heart surgery, in teaching and in leadership within his department and the Medical Center.

Doctor Brown, who became associated with the University of Louisville School of Medicine in 1957, has served from 1962 until the present as associate director of Commonwealth Curriculum Study. He served as chairman of the Curriculum Committee which developed the new curriculum program at the U. of L. School of Medicine. He was honored for his leading role in the planning of the new curriculum and his outstanding contributions as a teacher.

President's Luncheon Speaker Prescribes Dose of Laughter

A sense of humor is a prime requisite in learning to face our problems, Charles W. Jarvis, Texas dentist-humorist, told a crowd of 265 attending the 1964 KSMA Annual Meeting President's Luncheon at which he was the main speaker.

"So—You Have a Problem?" was the topic of Doctor Jarvis' highly entertaining talk before Kentucky physicians and their guests at the September 30 luncheon held in the Terrace Room of the Kentucky Hotel in Louisville.

"Everyone has problems", said Doctor Jarvis, who also remarked that the problem of medicare has everybody confused. "Government intervention into medical care will not benefit anyone", he stated, and added, "Today America is recognized as the paragon of medical care . . . that is because it has been left alone. I really believe that incentive and initiative mean something."

Continuing this subject, the San Marcos, Texan, who is a member of the AMA Speakers Bureau, remarked that incentive and initiative are not encouraged by governmental direction and manipulation.

In closing the address that kept his audience laughing for its duration, Doctor Jarvis reminded the crowd that "We can thank God for a sense of humor. We have problems, but we can still laugh at them."



The President's Luncheon at the 1964 Annual Meeting was regarded as an outstanding success. Shown above is a portion of the speaker's table during the Luncheon which was held in the Terrace Room of the Kentucky Hotel.

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS



PRO-BANTHĪNE (propantheline bromide) Assures Authoritative Anticholinergic Control in Gastrointestinal Dysfunctions

The clear and consistent therapeutic benefits of Pro-Banthīne (propantheline bromide) have made it the preferred anticholinergic for the past decade.

During that time, many compounds have been developed and proposed as alternatives. In the appraisal of Roach[1] ". . . few, if any, have seemed to offer a distinct improvement, . . ."

Early investigations showed that Pro-Banthīne (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthīne] and propantheline [Pro-Banthīne].

The name Pro-Banthīne (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE
Chicago, Illinois 60680
Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice –1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

Ky. Physicians Slated to Speak at SMA Meeting in Memphis

Thirteen Kentucky physicians are scheduled to speak at the 58th Annual Meeting of the Southern Medical Association in Memphis, Tenn., on November 16-19, according to J. Duffy Hancock, M.D., Louisville, a member of the SMA Board of Trustees.

Assisting the Committee on Scientific Work in preparing an "outstanding" scientific program were the section secretaries, including Douglas M. Haynes, M.D., Louisville, Section on Obstetrics, Andrew M. Moore, M.D., Lexington, Section on Plastic & Reconstructive Surgery, and Herman Wing, M.D., Louisville, Section on Industrial Medicine and Surgery. Sam A. Overstreet, M.D., Louisville, is on the SMA Council.

The meeting will feature three symposia, daily color TV, scientific and technical exhibits, and many scientific presentations. On the social side, there will be a President's Luncheon, Hospitality Hour, President's Dinner Dance, golf tournament. There will be a social hour for U of L medical alumni on Tuesday, November 17, at the Hotel Peabody, Tennessee Room, at 6:30.

"Office Management of Smoking Deterrents in the Adolescent" will be discussed by Irving B. Perlstein, M.D., Louisville, as part of a symposium on the "Problems of Adolescents" on November 19.

Participating in the Section of Gynecology will be A. J. Whitehouse, M.D., Lexington, and Laman A. Gray, M.D., Louisville. Doctor Whitehouse will speak on "The Systemic Uterine Curettage" on November 17 and Doctor Gray will speak on "Treatment of Endometriosis of the Large Bowel: Excision or Castration?" on November 18.

Herman Wing, M.D., and Thomas Marshall, M.D., will present "Arthropathies of the Hand: Clinical and Radiographic Diagnosis" before the Section on Industrial Medicine and Surgery and the Section on Physical Medicine and Rehabilitation on November 17.

At the Section on Medicine on November 18 Jerome E. Cohn, M.D., Lexington, will participate in a panel on "Pulmonary Function Testing and the Management of Chronic Pulmonary Disease". "The Surgical Management of Exophtalmos" will be discussed by Roderick MacDonald, Jr., M.D., Louisville, at the Section on Ophthalmology.

Paul Weeks, M.D., Lexington, will talk on "Injuries of the Digital Extensor Apparatus" at the Section on Plastic and Reconstructive Surgery on November 16. At the Section on Preventive Medicine Jesse W. Tapp, M.D., will be the discussant on "Infectious Hepatitis: Report of a Community Epidemic", on Tuesday, November 17.

Moderator of "Cardiac Surgery" on closed circuit TV on Tuesday, November 17 will be Frank Spencer, M.D., Lexington. Also participating in the Section on Surgery will be Gordon L. Hyde, M.D., Lexington, who will speak on "Selective Gastric Vagotomy".

John Harter, M.D., Louisville, will discuss "Postoperative Cardiopulmonary problems at a joint session of SMA and the Southern Chapter, American College of Physicians on November 16.



Following the President's Luncheon recipients of KMA's three major awards gather to take a closer look at their awards. From left to right—Lloyd Hall, M.D., Salyersville, Outstanding General Practitioner Award; Betty Wilson, Owensboro, R. Haynes Barr Award; William Bizot, M.D., Louisville, chairman of KMA Awards Committee; and Gaithel L. Simpson, M.D., Greenville, Distinguished Service Medal.

Drs. Simpson and Hall Honored by KMA at Annual Meeting

Gaithel L. Simpson, M.D., Greenville, and Lloyd M. Hall, M.D. Salyersville, were recipients of the two top KMA awards at the President's Luncheon on September 30.

Doctor Simpson, president of the KSMA in 1961-62, was awarded the Association's Distinguished Service Medal and Doctor Hall received the Outstanding General Practitioner Award.

A 1931 graduate of the University of Louisville School of Medicine, Doctor Simpson has served KMA in many capacities including serving as vice chairman of the Kentucky Rural Scholarship Loan Fund since the program began in 1946. He was chairman of the KSMA Medical Services Committee when it surveyed the state and sponsored the indigent care program in Kentucky.

Doctor Simpson is currently a member of the Board of Directors of the Kentucky Chamber of Commerce and has served as chairman of the Governor's Advisory Council to the Indigent Medical Care Program since its inception in 1961. He has testified twice before the House Ways and Means Committee for KMA against the King-Anderson Bill. He is also widely known for his conservation work.

Doctor Hall, Magoffin County's only practicing physician, has been in general practice in Salyersville for 31 years. He graduated from the University of Louisville School of Medicine. During the first 12 years of his practice he traveled on horseback and then, as the mountain roads improved, graduated to a jeep. He has been County Health Officer for six years and has been chairman of the County Board of Health for many years. He has been medical examiner for the local draft board for 25 years.

Elected Mayor of Salyersville in 1963, he served until moving outside of the city limits recently. He

was instrumental in getting the town its first water works and sewage system. Three years ago he was named "Man of the Year" by the businessmen of the town. He has a son who is a practicing physician, another son a senior medical student and his wife is a registered nurse.

This year's R. Haynes Barr Award was given to Mrs. Betty Wilson, Owensboro, leader of a four piece combo that has provided music for servicemen, hospitals, and rest homes for almost 40 years. Every Sunday for 23 years she and her orchestra have played at the former Veterans Hospital at Outwood.

Kentuckians to Participate in AMA Mental Health Congress

Two Kentuckians, Beverley T. Mead, M.D., assistant professor of psychiatry at the University of Kentucky, and Robert G. Cox, KMA executive assistant, will participate in the American Medical Association's Second National Mental Health Congress at the Palmer House in Chicago November 5-7.

Doctor Mead is co-chairman of a workshop section on enlisting community support for mental health in rural areas. This will be a part of one of 14 workshop sessions planned for the second day of the three-day Congress. Mr. Cox, who has been active in local and state mental health programs, will deliver an address on the role of county and state medical societies in community mental health during another session.

Also on the program will be Harold L. McPheeters, M.D., former director of the Kentucky Department of Mental Health, now with the New York Mental Health Department.

Mental Health Digest Ready

A summary of the Digest of Proceedings of the first Kentucky Congress on Mental Health sponsored by the Kentucky Medical Association is now available on request from the KMA Headquarters Office.

The summary was prepared by the Kentucky Association for Mental Health, one of the co-sponsors of the Congress, and is being mailed to all Congress participants. The Congress was held in Louisville, Thursday, May 14.

Message Center A Success

Approximately 350 messages were handled by the message center at the 1964 KMA Annual Meeting. This is the first time a central message center has been used at the meeting and comments on its efficiency and convenience indicate its success.

The center, which was manned by trained employees of the Yellow Pages Department of the Southern Bell Telephone Company, received special praise from the KMA House of Delegates.



Principal participants in the KEMPAC banquet on Monday evening, September 28 were George P. Archer, M.D., Prestonsburg, KMA president; Birch Bayh, Indiana Senator; Donald Wood, M.D., chairman of the Board AMPAC and President of Indiana State Medical Association; Hoyt D. Gardner, M.D., Louisville, chairman of the KEMPAC Board; Senator Frank Carlson, Kansas, who also participated in the program, was not present for the picture.

Senators Bayh and Carlson Speak at KEMPAC Dinner

Two viewpoints of the future of govenment and its relation to the medical profession were presented by Senators Birch Bayh, Indiana Democrat, and Frank Carlson, Kansas Republican, to the 285 physicians and their guests who attended the September 28 Kentucky Education Medical Political Action Committee Banquet at the Kentucky Hotel in Louisville.

Donald A. Wood, M.D., Indianapolis, chairman of the Board of the American Medical Political Action Committee (AMPAC) spoke on the history and purpose of AMPAC. The diners also heard an address by George P. Archer, M.D., president of the Kentucky Medical Association.

The annual KEMPAC social hour and banquet were held in conjunction with the 1964 Annual Meeting of the Kentucky Medical Association.

42 Play in 1964 Golf Tournament Dr. Scalzitti is Winner

C. J. Scalzitti, M.D., Louisville, was winner of the KMA Championship Trophy at the annual KMAGA Golf Tournament held during the Annual Meeting of the Kentucky Medical Association in Louisville, September 29 through October 1.

Kenton D. Leatherman, M.D., Louisville, was chairman of the KMA Golf Committee. The tournament, in which 42 members participated, was held at the Big Spring Country Club.

Doctor Leatherman announced the winners, who also included R. Glenn Greene, M.D., Owensboro, Low Net Trophy; Harvey B. Stone, M.D., Hopkinsville, Championship Trophy Senior Division; Henry H. Moody, M.D., Cynthiana, Low Net Trophy Senior Division.

Next year's tourney is tentatively scheduled for the Louisville Country Club. All golfers are urged to make plans for participating in the 1965 tournament which will be held Monday, September 20.



First official act of Dlelmas M. Clardy, M.D., Hopkinsville, (left) as KMA president was presentation of the Past President's Key to 1963-64 President George P. Archer, M.D., Prestonsburg.

Was Your Delegate Present?

ROLL CALL—

1964 House of Delegates*

KMA Annual Meeting

OFFICERS

		First Session	Second Session
Speaker	Garnett J. Sweeney	Present	Present
Vice-Speaker	George F. Brockman	Present	Present
President	George P. Archer	Present	Present
President-Elect	Delmas M. Clardy	Present	Present
Vice-President	Carlisle Morse	Present	Present
Vice-President	Carl Cooper, Jr.	Present	Present
Vice-President	John Dickinson	.....	Present
Secretary	Henry B. Asman	Present	Present
Treasurer	Keith P. Smith	Present	Present
Delegate to the AMA	Wyatt Norvell	Present	Present
Delegate to the AMA	J. Thomas Giannini	Present	Present
Delegate to the AMA	John C. Quertermous	Present	Present
Alternate Delegate to the AMA	Charles G. Bryant	.....	.....
Alternate Delegate to the AMA	William W. Hall	.....	Present
Alternate Delegate to the AMA	Charles C. Rutledge	Present	Present

TRUSTEES

District			
First	O. Leon Higdon	Present	Present
Second	Howell J. Davis	.....	.....
Third	Gabe A. Payne, Jr.	Present	Present
Fourth	Dixie E. Snider	.....	Present
Fifth	Alfred O. Miller	.....	.....
Sixth	Rex E. Hayes	Present	Present
Seventh	Donald Chatham	.....	Present
Eighth	W. Donald Janney	.....	Present
Ninth	Mitchel B. Denham	Present	Present
Tenth	Douglas E. Scott	Present	Present
Eleventh	Hubert C. Jones	Present	Present
Twelfth	Thomas O. Meredith	Present	Present
Thirteenth	Clyde C. Sparks	Present	Present
Fourteenth	William C. Hambley	Present	Present
Fifteenth	Robert E. Pennington	Present	Present

PAST PRESIDENTS

Past-President	David M. Cox	Present	Present
Past-President	Gaithel L. Simpson	Present	.....
Past-President	Richard G. Elliott (deceased)		
Past-President	Irvin Abell, Jr.	.....	Present
Past-President	Robert W. Robertson	.....	.....
Past-President	Edward B. Mersch	.....	.....

**The information in the Roll Call was taken from the attendance record cards signed by the delegates prior to the meetings of the House on September 28 and 30.*

DELEGATES
First District

County		First Session	Second Session
BALLARD	Glenn Baird	.....	.....
CALLOWAY	Hugh L. Houston	Present	Present
CARLISLE	John T. O'Neill	Present	Present
FULTON	G. F. Bushart	Present	.....
GRAVES	Robert Orr	.....	Present
HICKMAN	V. A. Jackson	.....	Present
LIVINGSTON			
McCRACKEN	R. M. Wooldridge	Present	.....
	W. B. Haley	Present	Present
	G. H. Widener	.....	.....
	O. L. Higdon (Alt.)	.....	Present
MARSHALL	J. R. Miller	Present	Present

Second District

DAVIESS	J. S. Oldham	Present	Present
	W. H. Hall	Present	Present
	B. H. Warren	Present	Present
HANCOCK	B. Pressley Smith	.....	Present
HENDERSON	Julian Cole	.....	.....
	Walter O'Nan (Alt.)	Present	Present
McLEAN	W. G. Edds	Present	Present
OHIO	R. E. Norsworthy	Present	.....
UNION	Wallace N. Bell	Present	Present
WEBSTER	John Logan	Present	Present

Third District

CALDWELL	Ralph Cash	.....	.....
CHRISTIAN	Guinn S. Cost	.....	.....
	R. C. Snowden (Alt.)	Present	Present
	Norma T. Shepherd	Present	Present
CRITTENDEN	R. M. Brandon	.....	.....
HOPKINS	Loman C. Trover	Present	Present
	F. A. Scott	Present	Present
LYON	James E. Hamilton	.....	.....
MUHLENBERG	Hylan Woodson	Present	Present
TODD	R. D. Lynn	Present	Present
TRIGG	John Futrell	.....	.....

Fourth District

BRECKINRIDGE	James G. Sills	Present	.....
BULLITT	R. S. Bowen	Present	.....
GRAYSON	Ray A. Cave	Present	.....
GREEN	J. W. Miller	.....	.....
HARDIN	R. T. Routt	Present	Present
HART			
LARUE	J. D. Handley	.....	.....
MARION	David Drye	.....	Present
MEADE	W. A. Cole, Jr.	.....	.....

Fifth District

JEFFERSON	Frank A. Bechtel	Present	Present
	Sam H. Black	Present	Present
	Elbert G. Christian	Present	Present
	Morgan R. Colbert	.....	.....
	William C. Durham	Present	Present
	Rudy Ellis	.....	.....
	Wilfrid C. Gettelfinger	Present	Present
	A. L. Goodman	Present	Present
	John Hemmer	.....	.....
	David W. Kinnaird	Present	Present



Discussion in the reference committees on Monday afternoon, September 28, following the first meeting of the House of Delegates, was spirited as demonstrated in Reference Committee No. 2 which reviewed the Council on Medical Education and Hospitals and the Council On Scientific Assembly Reports.

	Blaine Lewis	.....	Present
	Richard Mardis	.....	Present
	Homer B. Martin	Present	Present
	George F. McAuliffe	Present	Present
	Robert L. McClendon	Present	Present
	John Moorhatch	.....	Present
	Herman Moore	Present	Present
	Henry W. Post	Present	Present
	Carroll Robie	Present	Present
	W. Fielding Rubel	Present	Present
	James M. Riley	Present	Present
	William T. Rumage, Jr.	.....	.....
	Paul J. Ross	Present	.....
	Bernard Schoo	.....	.....
	Samuel M. Smith	Present	.....
	William B. Stodghill	Present	Present
	Robert C. Tate	Present	Present
	Edward Warrick, Jr.	Present	Present
	Sam Weakley	Present	Present
	John Wolford	.....	Present

Sixth District

ADAIR	M. C. Loy	Present	.....
BARREN	Eugene L. Marion	Present	.....
BUTLER	John C. Burris	.....	Present
CUMBERLAND	Joseph Schickel	.....	Present
EDMONSON			
LOGAN	G. B. Glenn	.....	Present
	C. V. Dodson (Alt.)	Present	.....
METCALFE	P. D. Hitchcock	.....	.....
MONROE	John C. Marsh	.....	.....
SIMPSON	L. F. Beasley	Present	Present
WARREN	Paul Parks	Present	Present
	Martin Wilson	Present	Present

Seventh District

ANDERSON	Boyd Caudill	Present	.....
CARROLL	Edgar S. Weaver	.....	.....
FRANKLIN	John Stewart	Present	Present
	Branham B. Baughman	Present	Present
GALLATIN	J. E. Esteves (Deceased)		
GRANT	C. C. Waldrop	Present	Present
HENRY	S. B. May	Present	.....
OLDHAM	H. B. Mack	Present	Present
OWEN	O. A. Cull	.....	.....
SHELBY	A. D. Doak	Present	Present
TRIMBLE	John I. Cooper	.....	.....

Eighth District

BOONE	L. C. Hess	Present	Present
CAMPBELL-KENTON	Carl J. Brueggeman	Present	Present
	Thomas Huth	Present	.....
	Paul Klingenberg	Present	Present
	R. Charles Smith	Present	Present
	Richard Allnutt	Present	Present
	Robert T. Longshore	Present	Present

Ninth District

BATH			
BOURBON	R. J. Wever	.....	.....
BRACKEN	J. M. Stevenson	Present	Present
FLEMING	L. W. Bowman	.....	.....
HARRISON	Henry Moody	Present	.....
MASON	Harry C. Denham	Present	Present
NICHOLAS	W. R. Kingsolver	.....	.....
PENDLETON	William M. Townsend	.....	.....
ROBERTSON			
SCOTT	J. C. Cantrill	Present	.....



Reference Committee chairmen and secretaries taking the dictation often work into the small hours during the Annual Meeting in order to meet the deadline. Shown above is Lewis Bosworth, M.D., Lexington, dictating the Reference Committee Report on Bylaws to Mrs. Patricia Hire of the KMA staff.



Members of the House of Delegates applaud as Everett H. Baker, M.D., Louisville, KMA president-elect, walks to the podium following his election by the House.

Tenth District

FAYETTE	W. L. Boswell	Present	Present
	N. L. Bosworth	Present	Present
	Harvey Chenault	Present	Present
	Carl H. Fortune	Present	Present
	M. R. Gilliam	.....	Present
	Arnold C. Williams (Alt.)	Present	.....
	A. M. Moore	Present	Present
	T. R. Bryant, Jr.	Present	Present
	Irvin F. Kanner	Present	Present
	J. H. Saunders	Present	.....
	W. L. Burke (Alt.)	.....	Present
	William R. Willard	Present	Present
	John F. Berry, Jr.	Present	Present
	D. B. Stevens	Present	Present
JESSAMINE	J. S. Williams	Present	Present
WOODFORD	Norman Fisher	Present	Present

Eleventh District

CLARK	Earl Rynerson	.....	.....
ESTILL	R. R. Snowden	.....	.....
JACKSON			
LEE			
MADISON	William D. Epling	Present	Present
	William C. Clause	.....	.....
MENIFEE	D. L. Graves	.....	.....
MONTGOMERY	R. J. Salisbury	Present	Present
OWSLEY	Mildred B. Gabbard	.....	.....
POWELL			
WOLFE	Paul F. Maddox	Present	.....

Twelfth District

BOYLE	Chris S. Jackson	Present	.....
CASEY			
CLINTON	Ernest A. Barnes	.....	.....
GARRARD	Paul J. Sides	Present	Present
LINCOLN	H. I. Frisbie	.....	.....
	James Blackerby (Alt.)	Present	Present
McCREARY	H. A. Perry	.....	.....
MERCER	J. H. Baughman	Present	.....
ROCKCASTLE			
RUSSELL	Charles E. Peak	.....	.....
WAYNE	John W. Simmons	.....	.....
	W. R. Kelsay, Jr. (Alt.)	.....	Present

Thirteenth District

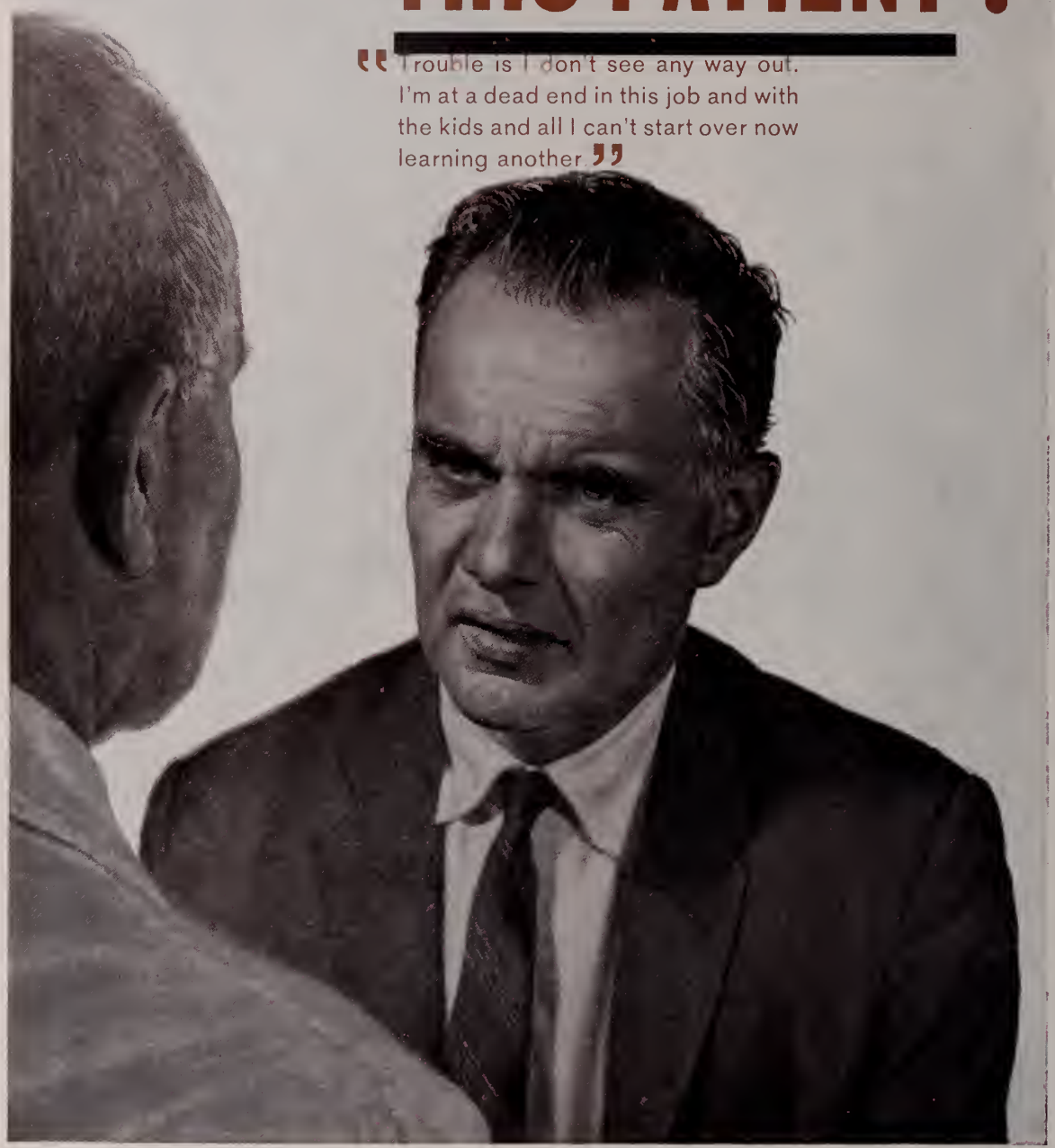
BOYD	Walter Cawood	Present	Present
	W. R. Duff	Present	.....
CARTER			
ELLIOTT	John F. Greene	.....	.....
GREENUP	C. B. Johnson	Present	Present
LAWRENCE	A. W. Wright	.....	.....
LEWIS	Elwood Esham	.....	Present
MORGAN	Morris L. Peyton	.....	.....
ROWAN	Herbert Hudnut	Present	Present

Fourteenth District

BREATHITT	Price Sewell, Jr.	.....	.....
FLOYD	Russell L. Hall	Present	Present
JOHNSON	James W. Archer	Present	Present
KNOTT	Gene T. Watts	.....	.....
LETCHER	J. B. Tolliver	.....	.....

Continued on Page 891

RECOGNIZE THIS PATIENT?



Indications: Depression, both acute (reactive) and chronic, especially when the depression is accompanied by anxiety, insomnia, and related symptoms. **Contraindications:** Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. **Side effects:** Side effects associated with 'Deprol' have consisted primarily of drowsiness and occasional dizziness, and infrequent skin rash and nausea. *Benactyzine hydrochloride* — Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

When you recognize depression and anxiety traceable to an emotionally charged situation with no somatic disorder

—*start the patient on 'Deprol'*

Typical situations in which 'Deprol' is indicated:

marital or other family problems ■ death of a loved one ■ financial worries ■ fear of cancer, heart disease or other life-threatening illness ■ pre- and post-operative apprehensions ■ retirement problems, and many other stressful situations which cause the patient to feel a sense of loss, guilt or unworthiness

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' restores normal sleep, relaxes physical tensions, and improves appetite.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is relatively nontoxic and free of side effects.
5. When depression and anxiety accompany physical illness, 'Deprol' is compatible with drugs used to treat these organic conditions.

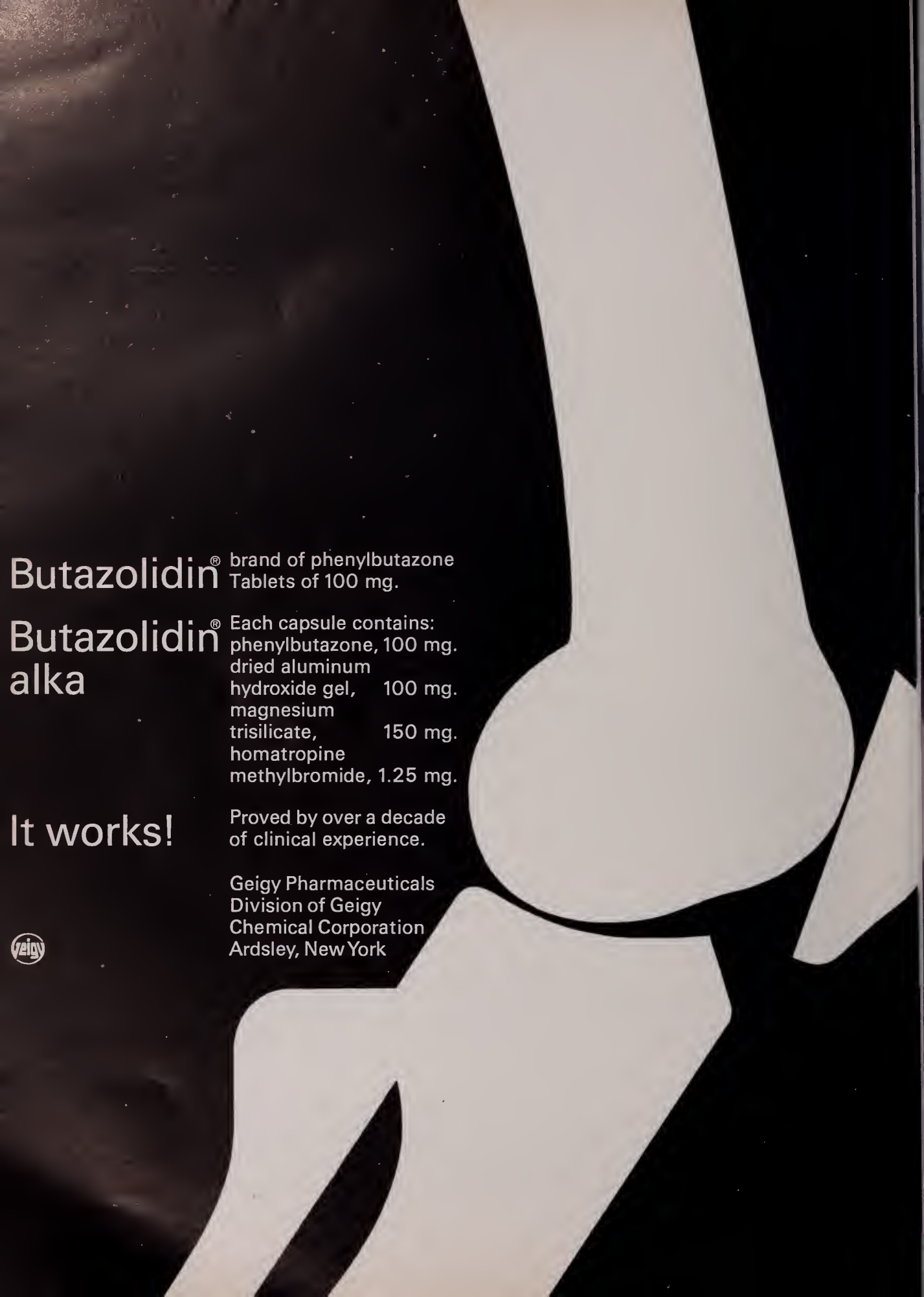
Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

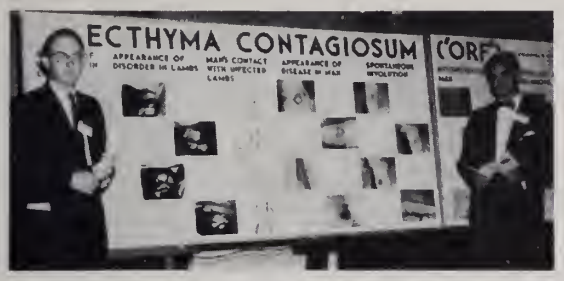
WALLACE LABORATORIES / *Cranbury, N. J.*

CD-3561

Meprobamate – Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis, and anaphylaxis. Treatment should be symptomatic and the drug not reinstituted. Isolated cases of agranulocytosis and thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. **Dosage:** Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and reduced gradually to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients. **Supplied:** Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg. *Before prescribing, consult package circular.*


Butazolidin® brand of phenylbutazone
Tablets of 100 mg.
Butazolidin® alka
Each capsule contains:
phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.
It works!
Proved by over a decade of clinical experience.
Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York
Geigy

MAGOFFIN			
MARTIN			
PERRY	Lyndon F. Combs	.....	.....
	Mary Fox (Alt.)	Present	Present
PIKE	Bill Clark	.....	Present
	B. W. Cassady	Present	Present
	Fifteenth District		
BELL	Charles B. Stacy	Present	Present
	M. J. Evans	.....	.....
CLAY	W. E. Becknell	Present	.....
HARLAN	E. M. Howard	Present	Present
	Philip J. Begley	.....	.....
KNOX	F. X. Sommer	.....	.....
LAUREL	E. C. Seeley	Present	Present
LESLIE			
WHITLEY	Harold B. Barton	Present	Present



Winning scientific exhibit at the Annual Meeting was "Ecthyma Contagiosum" By Ullin W. Leavell, M.D., Michael J. McNamara, and R. J. Muelling, Jr., M.D., all of Lexington. Doctor Leavell is pictured with the exhibit (left) and at the right is Benjamin B. Jackson, M.D., Louisville, chairman of the KMA Scientific Exhibits Committee.

1965 Annual Meeting Dates Set

September 21, 22, and 23 are the dates scheduled for the 1965 Annual Meeting of the Kentucky Medical Association, to be held once again in Louisville.

Headquarters for the meeting will again be the Kentucky Hotel. Scientific sessions and scientific and technical exhibits will be housed at the Convention Center, as was done this fall. Delmas M. Clardy, M.D., Hopkinsville, KMA president, and members of the Council on Scientific Assembly will meet on November 11 to discuss preliminary plans for the 1965 Annual Meeting.

Laboratory at Meeting Tests 215

The clinical laboratory health evaluation test offered for the first time this year at the Annual Meeting was taken by 215 persons, according to Malcolm Barnes, M.D., who was in charge of the project.

Doctor Barnes said 35 pathologists and laboratory personnel from throughout the State worked in the lab during the meeting. The Kentucky Society of Pathologists sponsored the program in cooperation with the Kentucky, Louisville, and Central Societies of Medical Technologists. The limited clinical examination program, offering six blood chemistry determinations, urinalysis, a hemocrit on blood, and a white blood count, will be offered again at the 1965 Annual Meeting.



Delmas M. Clardy, M.D., KMA president, admires the portrait of the late Arch Cole, Ph.D., for many years professor of anatomy at the University of Louisville School of Medicine. The medical school Class of 1953 commissioned the painting and presented it to the school. Doctor Cole died in an automobile accident in 1962.

Dr. Cole Memorialized

S. Randolph Scheen, M.D.*

During the tenth annual reunion of the Class of 1953, University of Louisville School of Medicine, at a meeting during the 1963 Kentucky Medical Association annual session in Lexington, the class voted to commission a painting of our late beloved professor of anatomy, Doctor Arch Cole. Mr. Harry Cronen was commissioned to do the oil portrait, and the painting was presented during the Kentucky Medical Association meeting this year. It will hang alongside the other dignified and beloved scholars and teachers of the University.

Doctor Cole will long be remembered by all of his students. We all considered it an honor to study under him. He was not only a teacher to all of us, but also a friend to whom any of us could turn at anytime for help. Our association with a man such as Doctor Cole will long be remembered in our hearts, and I am sure we are all better physicians for having had his guidance on our way up the medical ladder. This painting will serve to remind us of a man who played a major role in the lives of many physicians.

* *Doctor Scheen was chairman of the committee from the Class of 1953 of the U. of L. School of Medicine, who arranged for the painting and its presentation to the school.*

$1000 Club Plaque Unveiled

Unveiling of a "$1000 Club Plaque" in the main lobby of the University of Louisville Medical-Dental Research Building took place on Tuesday, September 29, during the KMA Annual Meeting. Speakers included George A. Sehlinger, M.D., president of the Jefferson County Medical Association; Donn L. Smith, M.D., dean of the U of L School of Medicine; and Walter S. Coe, M.D., president of the U of L Medical Alumni Association. Doctor Coe participated in the unveiling along with a representative of the dental profession.



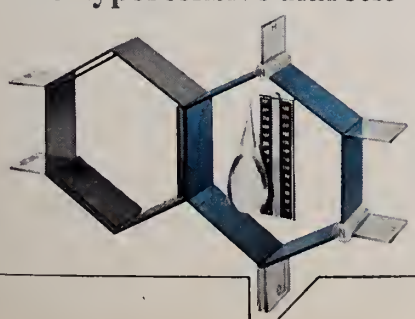
Just turned hypertensive

A 15 mm. Hg drop in diastolic pressure would also suit her very well

For suitably gradual, physiologic hypotensive treatment



HYDROMOX®
QUINETHAZONE-TABLETS
antihypertensive diuretic



HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

Lederle

8370-4



David Kinnaird, M.D., Louisville, chairman of Reference Committee No. 5, reports to the House of Delegates at its second meeting on Wednesday, September 30. Vice Speaker George F. Brockman, M.D., Greenville, is at the podium in the background.

House of Delegates Votes on Association Name Change at Annual Meeting; Considers Other Important Resolutions During Busy Sessions

At the 1964 Annual Meeting, the House of Delegates voted to change the constitution so that the name of the Association is now KENTUCKY MEDICAL ASSOCIATION. The word "State" was dropped because many of our suppliers and others confused our Association with state government.

The House accepted recommendations of the 1963-64 President, Geroge P. Archer, M. D., Prestonburg, recommending that Area Hospital Planning be supported by the Association on a voluntary basis only.

The House voted to establish a Judicial Council to handle disciplinary and ethical problems in the future. This group was given broad powers and the only appeal from the KMA Judicial Council will be to the Judicial Council of the American Medical Association.

A mandatory indoctrination program for new members becoming effective January 1, 1965, was adopted. The new members will have a two-year period in which to take the course. The time, place and content are to be approved by the Board of Trustees.

Once more, the House of Delegates went on record opposing the extension of compulsory social security coverage to the self-employed physician.

The Digest of Proceedings of the 1964 KMA House of Delegates Meeting will appear in the December, 1964, Journal of KMA. Completed details on all of the actions of the House will then be printed.

For the second time, the House met on Monday morning and the reference committees met Monday afternoon. The House acted on more than 65 reports of officers, councils, committees, boards, and resolutions. The second meeting was held Wednesday evening, September 30.

Among the six resolutions that were considered by the House, Resolution F, relating to participation in new Third Party Plans, introduced by the Campbell-Kenton County Medical Society, was passed.

Before the coffee break a five-minute address was delivered by Mrs. Bettye Fisher, Evansville, Indiana, past president of the American Association of Medical Assistants. Her talk was very well received.

House members were served coffee during a break in the September 28 meeting by members of the Board of Directors of the Kentucky State Association of Medical Assistants.

COMPARATIVE REGISTRATION FIGURES

KSMA Annual Meetings

	Louisville 1955	Louisville 1956	Louisville 1957	Louisville 1958	Louisville 1959	Louisville 1960	Louisville 1961	Louisville 1962	Lexington 1963	Louisville 1964
KSMA Members	938	923	1094	971	997	1021	996	1014	865	924
Guest Physicians	122	157	178	166	165	203	194	208	141	157
Interns-Residents	106	105	142	108	128	105	102	102	69	108
Medical Students	299	305	328	269	280	289	237	176	59	128
Registered Nurses	55	15	28	22	34	25	31	59	31	34
Exhibitors	174	218	176	211	200	239	204	232	212	297
Guests	121	108	151	164	86	99	132	123	132	125
Technicians—										
Office Assistants	50	54	54	45	63	33	57	71	22	61
TOTAL ATTENDANCE	1865	1885	2151	1956	1953	2014	1953	1985	1531	1844

KMA Records Show All-Time High Membership

Last year at this time it was reported in The Journal that the records of the Kentucky Medical Association membership department showed an all-time high number of active physicians in the state who were active members of KMA and the AMA.

This year another record has been set in membership. Records show total membership of 2,167, as compared to 2,152 last year. Sixty-five counties in Kentucky show 100% KMA membership. In thirty-seven of these counties, all physicians are members of the American Medical Association.

The chart below, which includes membership records as of October 20, will show that an additional number of counties could have 100% membership if one or two physicians became members.

Who are Members of KMA and AMA

(October 20, 1964)

COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA	COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA	COUNTIES	ACTIVE PHYSICIANS	MEMBERS KMA	MEMBERS AMA
Adair	8	7	6	Graves	15	14	14	Menifee (*) (**)	1	1	1
Allen	5	5	4	Grayson (*) (**)	6	6	6	Mercer	13	12	11
Anderson	4	3	1	Green (*) (**)	6	6	6	Metcalfe (*) (**)	2	2	2
Ballard	5	5	5	Greenup	9	8	8	Monroe (*) (**)	7	7	7
Barren	23	22	21	Hancock	2	1	0	Montgomery	8	6	6
Bath	4	1	1	Hardin	27	25	21	Morgan (*)	4	4	2
Bell	27	21	21	Harlan	38	31	31	Muhlenberg (*)	11	11	10
Boone	13	13	12	Harrison (*)	8	8	5	Nelson	9	8	7
Bourbon	13	13	6	Hart (*) (**)	5	5	5	Nicholas (*)	2	2	0
Boyd	51	49	49	Henderson	24	21	21	Ohio	8	5	4
Boyle	21	17	15	Henry (*) (**)	5	5	5	Oldham (*) (**)	6	6	6
Bracken (*) (**)	3	3	3	Hickman (*)	3	3	2	Owen	3	2	2
Breathitt (*) (**)	3	3	3	Hopkins (*)	38	36	35	Owsley (*) (**)	2	2	2
Breckinridge	6	5	4	Jackson (*) (**)	2	2	2	Pendleton (5)	3	3	1
Bullitt (5) (**)	5	5	5	Jefferson	798	724	638	Perry (*)	16	16	15
Butler (*) (**)	2	2	2	Jessamine (*)	5	5	3	Pike	41	24	23
Caldwell	6	5	5	Johnson	12	11	11	Powell	2	0	0
Calloway	15	14	14	Kenton	89	85	82	Pulaski	28	27	26
Campbell	59	51	48	Knott (*) (**)	3	3	3	Robertson	1	0	0
Carlisle	3	2	2	Knox	7	6	3	Rockcastle	3	1	0
Carroll	7	6	5	Larue (*)	4	4	2	Rowan	9	6	6
Carter (*)	3	3	2	Laurel (*)	10	10	9	Russell (*)	5	5	4
Casey (*) (**)	4	4	4	Lawrence	7	6	6	Scott (*)	8	8	4
Christian	37	27	26	Lee	2	1	1	Shelby (*) (**)	8	8	8
Clark	14	11	9	Leslie	2	0	0	Simpson	7	4	2
Clay (*) (**)	6	6	6	Letcher	14	9	8	Spencer	5	2	2
Clinton (*) (**)	3	3	3	Lewis (*)	2	2	1	Taylor (*)	9	9	7
Crittenden (*) (**)	3	3	3	Lincoln (*) (**)	3	3	3	Todd (*) (**)	3	3	3
Cumberland	2	1	1	Livingston (*)	3	0	0	Trigg	5	3	3
Davies	67	65	65	Logan (*) (**)	10	10	10	Trimble (*) (**)	2	2	2
Edmonson (*) (**)	2	2	2	Lyon	3	2	2	Union (*) (*)	6	5	5
Elliott (*) (**)	1	1	1	McCracken	61	55	54	Warren	40	37	36
Estill (*) (**)	4	4	4	McCreary (*) (**)	2	2	2	Washington (*) (**)	5	5	5
Fayette	333	274	243	McLean (*)	4	4	0	Wayne (*)	6	6	5
Fleming (*)	4	4	1	Madison (*)	25	25	24	Webster (*) (**)	7	7	7
Floyd	17	11	10	Magoffin (*)	1	1	0	Whitley	21	20	19
Franklin	32	30	28	Marion (5) (**)	9	9	9	Wolfe (*) (**)	1	1	1
Fulton (*) (**)	9	9	9	Marshall (*) (**)	10	10	10	Woodford	9	6	3
Gallatin	0	0	0	Martin	1	0	0				
Garrard (*) (**)	3	3	3	Mason ()	13	13	10				
Grant (*) (***)	4	4	4	Meade (*)	3	3	2	TOTAL	2448	2167	1957

* 100% KMA ** 100% AMA

Note: Report includes teaching staffs at medical schools, physicians i n Public Health, Mental Institutions, T.B. Hospital, VA Hospital, etc.

Health Exam. Survey Set

The Public Health Service's Health Examination Survey will begin October 15 at Barbourville and will be conducted over a period of four weeks. A sample of the child population, ages 6 through 11 years, chosen by a scientific sampling process from Bell, Knox and Whitley Counties, will be examined. This is a continuing project resulting from legislation passed by Congress in 1956.

The purpose of the survey is to collect on a uniform basis statistical information on various aspects of child health and to obtain data on certain physical and physiological measurements of these children. Approximately 200 children will be examined. One such survey has already been conducted in the Louisville area.

Meyer Elected by Nat'l. Druggists

E. Crawford Meyer, Jeffersontown, was elected a vice president of the National Association of Retail Druggists at the association's 66th annual convention in San Francisco. He is a past president of the Kentucky Pharmaceutical Association.

KSAMA Organizes New Chapter

Hardin-Larue County is the most recent chapter of the Kentucky State Association of Medical Assistants, organized at a meeting September 20 at Elizabethtown. Officers of the chapter were installed October 8 by Miss Dorothy Downs, Louisville, KSAMA president.

Continuing Educational Opportunities

From The

KSMA Postgraduate Medical Education Office

IN KENTUCKY

NOVEMBER

11-12	"The Clinical Application of Pulmonary Physiology", University of Kentucky Medical Center, Lexington
12	Pediatrics, "Refresher Course", 8:00 a.m.-5:00 p.m., University of Kentucky Medical Center, Lexington
19	University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington
27	"Cardiology Night", 7:30 p.m.-9:00 p.m., University of Kentucky Medical Center, Lexington

DECEMBER

3	"Professor's Day", 9:00 a.m.-3:00 p.m., University of Kentucky Medical Center, Lexington
10	Pediatrics, "Refresher Course", 8:00 a.m.-5:00 p.m., University of Kentucky Medical Center, Lexington
17	University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington
17	KMA Joint Trustee District Meeting, 4th, 5th and 7th Districts, Dinner Meeting, Medical Arts Building, Louisville

JANUARY

6, 13 20, 27	"Electrocardiogram Interpretation", 7:00 p.m. to 9:00 p.m., Louisville General Hospital, Louisville
7	"Professor's Day", 9:00 a.m. to 3:00 p.m., University of Kentucky Medical Center, Lexington
14	Pediatrics, "Refresher Course", 8:00 a.m.-5:00 p.m., University of Kentucky Medical Center, Lexington
21	University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington
27	"Cardiology Night", 7:30 p.m.-9:00 p.m., University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

NOVEMBER

16-19	Southern Medical Association, Memphis, Tennessee
20-21	American Psychiatric Association, Bellevue Stratford Hotel, Philadelphia, Pennsylvania
28-29	American College of Chest Physicians, Interim Meeting, Miami Beach, Florida
29	National Conference on Medical Aspects of Sports, AMA, Miami Beach, Fla.
29-Dec. 2	AMA Clinical Meeting, Miami Beach, Florida

DECEMBER

4-5	Association for Research in Nervous & Mental Disease, Roosevelt Hotel, New York
5-10	American Academy of Dermatology, Palmer House, Chicago, Illinois
8	Southern Surgical Association, Boca Raton Hotel, Boca Raton, Florida
9-10	Postgraduate Course in Ophthalmology, The Cleveland Clinic Educational Foundation, Cleveland, Ohio.
9-12	American Academy for Cerebral Palsy, Americana Hotel, New York.

JANUARY

14	Northern Kentucky Seminar, KAGP, Cincinnati, Ohio
25-27	American College of Surgeons, Sectional Meeting, Atlanta Biltmore Hotel, Atlanta, Georgia

FEBRUARY

5-10	Congress on Medical Education, Palmer House, Chicago, Illinois
25-March 2	American Dermatological Association, Boca Raton Hotel, Boca Raton, Florida







TAKE 5

...and find that a TB screening test has never been quite so easy

SWAB THE ARM— UNCAP A TINE TEST— PRESS—DISCARD THAT'S ALL THERE IS TO IT.

Comparable to the Mantoux in accuracy and sensitivity, the TUBERCULIN, TINE TEST is now available in plastic-capped units uniquely suited to general practice needs. They are so simple to use that you can test every patient with ease. Since it requires no refrigeration, the new package of five Tine Test units can stand on any convenient table in your examining rooms, ready for routine use. Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis.

available as the new individually-capped unit, boxes of 5, or in cartons of 25

TUBERCULIN, TINE TEST

(Rosenthal) Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. 7899-4

Lederle

Trustees of Wills Eye Hospital Appoint Dr. Keeney

Arthur Hail Keeney, M.D., has been appointed ophthalmologist-in-chief of the Wills Eye Hospital, Philadelphia, the largest institution in the Western hemisphere devoted excusively to diseases of the eye, according to an announcement from the hospital's trustees.



Doctor Keeney

Docotor Keeney, who has served KMA as chairman of the Committee on Highway Safety, will assume his new post after January 1. He will supervise all medical activities in the hospital, including a training program for 21 resident surgeons and research activities of a full-time staff of 40.

A member of the KMA Journal's Board of Consultants on Scientific Articles, Doctor Keeney is also associate professor of ophthamology at the U of L School of Medicine, a charter member f the Kentucky Society for the Prevention of Blindness, and former President of the Kentucky EENT Society.

In 1956, he became the sixty Kentuckian elected to the 100-year-old American Ophthalmological Society and has served that society as a representative to the American Committe on Optics and Visual Physiology. He is the ophthalmic member of the AMA Committee on Medical Aspects of Automotive Safety.

KMA Announces Addition of 13 New Members

Thirteen physicians have recently become new members of the Kentucky Medical Association, according to a recent review of the membership roster. As of October 7, the roles show the addition of the following names:

George C. Cheatham, M.D., and Robert P. Simmons, M.D., Greensburg; H. W. Ford, M.D., and Paul W. Schaper, M.D., Benton; and E. H. Kremer, III, M.D., William L. Miller, and J. Day Shanklin, M.D., all of Louisville.

Other new members are: George C. Barber, M.D., Morehead; Luis E. Davila, M.D., Highland Heights; F. P. Fornaris, M.D., Glasgow; Keith Linville, M.D., Central City; John A. Ritter, M.D., Harlan; and William T. Watkins, M.D., Somerset.

Twelve Kentucky M. D.'s Receive Fellowship in ACS

Twelve Kentucky physicians were among those inducted as new Fellows of the American College of Surgeons during the Clinical Congress of the world's largest organization of surgeons in Chicago, October 5-9.

The Fellowship degree entitles the recipient to use the designation "F. A. C. S." following his name and and is awarded to those who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in surgery, and who give evidence of good moral character and ethical practice.

Kentucky's new ACS Fellows are: Harry A. Hamilton, Jr., M.D. Corbin; Herbert J. Levin, USA, Fort Knox; Clarence J. McGruder, Jr., M.D., Henderson; John W. Greene, M.D., and Charles H. Nicholson, M.D., Lexington; Milton Comer, M.D., Don L. Harmon, M.D., Burton M. Heine, M.D., William J. Sandman, Jr., M.D., and Charles K. Sergeant, M.D., all of Louisville; Clifton E. Lowry, M.D., and William A. McManus, M.D., Owensboro.

Ky. Surgeons Go To Vietnam

Two Kentucky surgeons, Vernon H. Fitchett, M.D., Madisonville, and Charles C. Kissinger, M.D., Henderson, left recently to go to Vietnam to practice in civilian medical facilities in the war-torn Asian country.

Doctor Kissinger left September 29 to practice in Saigon's largest hospital with a team of three other American physicians. His 30-day volunteer tour of duty is sponsored by CARE. Doctor Fitchett, a neurosurgeon, will spend two years at Da Nang, South Vietnam, under the United States' program of aid being carried out by the Department of Health, Education, and Welfare.

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

"feels wonderful...cleared head entirely"*

(clearly decongested with Dimetapp)



Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; Phenylephrine hydrochloride 15 mg.; Phenylpropanolamine hydrochloride, 15 mg.)

In sinusitis, colds, U.R.I., Dimetapp lets your "stuffed-up" patients *breathe easy again.* Each long-acting Extentab provides clear relief for up to 10-12 hours, yet seldom causes drowsiness or overstimulation.

BRIEF SUMMARY: ***Indications:*** Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. ***Side Effects:*** In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. ***Precautions:*** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. ***Contraindications:*** Antihistamine sensitivity. Not recommended for use during pregnancy.

*Clinical report on file, Medical Department, A. H. Robins Co., Inc.

A. H. ROBINS CO., INC., RICHMOND 20, VA.



THE ULCER LIFE

In this "pop art" assemblage, artist Bob Sullivan depicts "the ulcer life" as man-in-a-box. The wall of nails closing in might well symbolize the torturous demands of a rigid, conformist society. As for the man, his disembodied psyche moves relentlessly onward with the blank, fixed stare of a man who has lost control of his own destiny. Small wonder that his gastric mechanism rebels.

NUMBER 1 IN A SERIES

for the ulcer life:
a new strength of glycopyrrolate

ROBINUL® FORTE
2 mg. per tablet

ROBINUL®-PH FORTE
glycopyrrolate 2 mg. phenobarbital 16.2 mg. (warning: may be habit forming)

When glycopyrrolate was first introduced, clinicians were immediately impressed by the remarkable ability of this compound to exert a more specific pharmacologic action on the gastrointestinal tract than on other organ systems. For example, they often found that in difficult patients the dosage could easily be adjusted upwards to achieve the desired suppression of both hypertonicity and secretion . . . without paying the penalty of side effects intolerable to the patient. Thus, it is no surprise that many clinicians suggested that a double-strength 2 mg. tablet of glycopyrrolate would be both practical and useful. For those patients ordinarily unresponsive to anticholinergics or for those exhibiting the more prominent symptoms, the new Forte dosage forms are a worthwhile addition to your ulcer armamentarium.

BRIEF SUMMARY

INDICATIONS: In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

PRECAUTIONS: Administer with caution in the presence of incipient glaucoma.

SIDE EFFECTS: Dryness of mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

DOSAGE: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day: in the a.m., early p.m., and at bedtime.

See product literature for full prescribing information.

A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA | PHARMACEUTICALS | RESEARCH Robins

MEDICAL SCHOOL NEWS

U.L. Cancer Radiation Center Dedicated October 17

The University of Louisville School of Medicine's new Cancer Radiation Center at Floyd and Walnut Streets, was dedicated in ceremonies October 17 at the Center. Donn L. Smith, M.D., Dean of the medical school, officially accepted the facility.

The center, to be used principally for cancer research and treatment, was financed largely by gifts from the Honorable Order of Kentucky Colonels and the American Cancer Society, and cost around $600,000. Main speaker at the dedication was J.W.J. Carpender, M.D., chief of radiotherapy at the University of Chicago School of Medicine and president of the American Board of Radiology.

Plaque Unveiled

A plaque honoring 169 financial supporters of the University of Louisville School of Medicine's Medical-Dental Research Building was unveiled September 29 in the building's main lobby. Honored were persons who contributed $1,000 or more toward the $3,400,000 unit.

It was announced that grants for medical and dental research received by U. of L. since the opening of the building in April, 1963, new total $3,351,720.

Grants Received

A $10,000 grant to the University of Louisville from the American Cancer Society has been divided by the University research committee to support seven new cancer-research projects and continue another.

The money will go to support studies in the following fields by the researchers named: leukemia, $800—Elton Heaton, M.D., and Giovanni Raccuglia, M.D.; Cancer of the cervix, $900—William L. Miller, M.D.; early stages of leukemia, $1,000—Leonard E. Reisman, M.D.; and characteristics of tumor cells, $700—Thomas G. Scharff, Ph.D.

Other studies, their grants, and the scientists in charge of the research are: possible role of D.N.A. in cancer, $1,487—Frank Swartz, Ph.D.; new equipment for the early detection of throat cancer, $2,154— F. Norman Vickers, M.D.; cancer of the uterus, $650—Paul Young, M.D.; and the continuation of cancer research, $1,680 to Condict Moore, M.D.

A grant of $10,000 from the National Dairy Council for studies of calcium metabolism was recently awarded to Felix Bronner, Ph.D., associate professor of physiology and biophysics.

U.K. Researchers Get Grants For Smoking-Effects Study

Two University of Kentucky Medical faculty members, Jerome E. Cohn, M.D., and E. Douglas Rees, M.D., both of the department of medicine, have received grants from the American Medical Association Education and Research Foundation to study different phases of the effect of tobacco smoking on health.

Doctor Cohn, who received a grant of $70,790, will study the effect of smoking on the lungs. Doctor Rees received $21,660 to investigate the effect of certain cigarette particles on chromosomes.

In a separate grant, the Milbank Memorial Fund of New York City has awarded a $10,000 grant to the Medical Center for support of a new residency program in community medicine. Kurt W. Deuschle, M.D., chairman of the department, will coordinate the program.

The U.S. Department of Health, Education and Welfare, Division of Health Research Facilities, has announced the award of a $125,000 grant to the Medical Center to assist in the construction of an off-campus animal facility.

Faculty Changes and Appointments

The University of Kentucky Board of Trustees have recently approved the following Medical Center faculty appointments and changes:

Appointments: Billie M. Ables, Ph.D., attending in clinical psychology in the department of psychiatry; David Bruce, M.D., instructor, and James R. Collins, M.D., instructor, both in the department of anesthesiology; Robert N. McLeod, Jr., M.D., assistant professor, department of pediatrics; and William Norton, M.D., physician in the University Health Service and assistant professor of medicine.

Other new appointments are: David Peck, Ph.D., instructor in anatomy; Keene A. Watson, M.D., assistant professor of community medicine; and James F. Zolman, Ph.D., assistant professor of physiology and biophysics.

The following changes were announced later: Ralph Shabetai, M.D., associate professor of medicine; Carl H. Fortune, M.D., clinical professor of medicine; Abdel Rahim, M.D., associate clinical professor of community medicine, and Stanley L. Block, M.D., associate clinical professor of psychiatry.

EENT Society Elects Officers

Alvin C. Poweleit, M.D., Covington, was installed as president of the Kentucky Eye, Ear, Nose and Throat Society at a meeting held in conjunction with the KMA Annual Meeting on October 1. Other officers are Roy Martin, M.D., Louisville, president-elect; and Edward C. Shrader, M.D., Louisville, secretary-treasurer. Following scientific sessions at the Convention Center, the group had a dinner and social hour at Stouffers.

Dr. Chumley Re-Elected

Jack L. Chumley, M.D., Louisville, was re-elected president of the Heart Association of Louisville and Jefferson County at the October 15 meeting of the Association at the Brown Hotel. Doctor Chumley, who is Scientific Editor of The Journal of KMA, is a clinical associate in medicine at the University of Louisville School of Medicine.

Chest Physicians Choose Gordon

Newly elected officers of the Kentucky Chapter, American College of Chest Physicians are Armond Gordon, M.D., Louisville, president; Porter Mayo, M.D., Lexington, vice president; and Alex Saliba, M.D., Hazlewood, secretary-treasurer. They were elected during the KMA Annual Meeting on Sptember 30. Their scientific sessions were held jointly with the Kentucky Thoracic Society and were followed by a social hour and dinner at the Kentucky Hotel. Scientific

AMA Appoints Panel of Nurses

The American Medical Association has announced the appointment of an ad hoc panel of professional nurse consultants to serve as advisors to AMA's Committee on Nursing.

The panel, which held its first meeting October 16 in Philadelphia, will inform the Committee of recent trends in nursing education and service and offer advice on future programming. In turn, the Committee will acquaint the panel with AMA programs and activities in the nursing area. The formation of the panel demonstrates the intent of the medical profession to work closely with its nursing colleagues toward the ultimate goal of optimal patient care.

Medical Assistants Hold Workshop

The Kentucky State Association of Medical Assistants held its first membership extension Workshop at Lexington on October 4 according to Miss Dorothy Downs, Louisville, KSAMA president.

Members from the ten counties represented were welcomed to the meeting by Andrew M. Moore, M.D., president of the Fayette County Medical Society. Also on the program were Nathaniel L. Bosworth, M.D., Lexington, and Jack L. Chumley, M.D., Louisville, chairman of the KSAMA Advisory Board. A variety of medical and related topics were presented during the one-day session.

Pertinent Paragraphs

The American Medical Association will sponsor a Conference on Blood and Blood Banking December 11-12 at the Drake Hotel in Chicago, announced Gunnar Gundersen, M.D., chairman of the AMA Committee on Blood. Further information on the Conference, which is directed toward the practicing physician, may be obtained from the Department of Environmental Health, American Medical Association, 535 North Dearborn St., Chicago, Ill.

Winners of the 1965 essay contest of the American College of Chest Physicians will receive cash awards in the amounts of $500, $300, and $200, for the best essays prepared by undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases. Additional information may be obtained by writing Mr. Murray Kornfeld, Executive Director, ACCP, 112 E. Chestnut Street, Chicago, Ill. 60611.



Our firm makes no pretense of an ability to forecast market movements. Our theory of investment involves buying sound, growing companies in sound growing industries. Over the years this theory has proved outstandingly successful.

J. J. B. HILLIARD & SON
• Louisville • Lexington • Owensboro • Hopkinsville
Bloomington • Columbus, Ind.

MEMBER New York Stock Exchange
MEMBER Midwest Stock Exchange
ASSOCIATE MEMBER American Stock Exchange

KMA Annual Meeting Guests Express Appreciation

"Just a note to tell you how much I appreciated the invitation to join you at lunch and for some of the meeting of the Kentucky State Medical Association. The luncheon was an enjoyable occasion, and I want to congratulate you upon a most well organized meeting.

Thanks for asking me."

R. H. Kampmeier, M.D., President, Tennessee Medical Association

"I certainly enjoyed my stay in Louisville and wish to express my appreciation and thanks for your courtesy and hospitality."

George J. Hamwi, M.D., Professor of Medicine, Ohio State University College of Medicine

"I thoroughly enjoyed my visit to Louisville and the opportunity to participate in your 1964 Annual Meeting. Please convey to the officers of KMA and particularly to your headquarters staff my appreciation for the warm hospitality that was accorded me and the many little things that were done to make my stay so pleasant."

Leon J. Warshaw, M.D. New York, New York

"It was a very great pleasure to meet with the group in Louisville. I enjoyed both the scientific and the social affairs tremendously . . . . . Most of all I appreciated the excellent organization of your meetings, which is indeed a great boon to the speakers . ."

Elsie R. Carrington, M.D., Research Professor of Obstetrics and Gynecology Women's Medical College of Pennsylvania

"Everyone was most courteous and I did enjoy myself very much . . ."

Kenneth R. Byerly, Associate Professor of Journalism, University of North Carolina

"I enjoyed appearing before the Kentucky State Medical Association in Louisville . . . . . Please accept my sincere thanks for the many kindnesses extended to me."

Noble O. Fowler, M.D., Professor of Medicine, University of Cincinnati College of Medicine

"I enjoyed very much my visit with your group in Louisville . . . . . and I appreciated the honor of having a small part in your program."

H. R. McCarroll, M.D., Associate Professor of Orthopaedic Surgery, Washington University School of Medicine

"You and your staff were most hospitable during the Annual Meeting in Louisville . . . . . all arrangements, before and during the Meeting, were most satisfactory."

Thomas E. Shaffer, M.D., Professor of Pediatrics, Ohio State University College of Medicine

"I should like, at this time, to express my thanks to the Council on Scientific Assembly for their fine hospitality."

D. Emerick Szilagyi, M.D., Henry Ford Hospital, Detroit, Michigan

"It was a real pleasure having the opportunity to attend the Kentucky State Medical Association Annual Meeting, and to speak to the General Session. I also enjoyed talking to the anesthesiology group in the afternoon."

C. R. Stephen, M.D., Professor of Anesthesiology Duke University Medical Center

"I appreciated very much the opportunity to be with the Kentucky State Medical Association in Louisville, and I want to thank you for your hospitality."

Trawick H. Stubbs, M.D., Director, Community Mental Health Service, State of Georgia Department of Public Health

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(As of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of filing: October 8, 1964.

2. Title of Publication: THE JOURNAL OF THE KENTUCY MEDICAL ASSOCIATION.

3.. Frequency of issue: Monthly

4. Location of known office of publication: 3532 Janet Avenue, Louisville, Ky., 40205.

5. Location of the headquarters or general business offices of the publishers: Same as above.

6. Names and addresses of Publisher, Editor, and Managing Editor: Publisher, Kentucky Medical Association, 3532 Janet Avenue, Louisville, Ky., 40205; Editor, Sam A. Overstreet, M.D., 810 Heyburn Building, Louisville, Ky. 40202; Managing Editor J. P. Sanford, 3532 Janet Avenue, Louisville, Ky., 40205.

7. Owner: Kentucky Medical Association, 3532 Janet Avenue, Louisville, Ky., 40205; President, Delmas M. Clardy, M.D., 901½ E. Main St., Hopkinsville, Ky., 42240; Secretary, Henry B. Asman, M.D., Medical Arts Building, Louisville, Ky. 40217; Treasurer Keith P. Smith, M.D., Corbin, Ky., 40701.

8. Known bondholders, mortgagees and other security holders owning or holding 1% or more of total amount of bonds, mortgages or other securities: None.

9. Paragraphs 7 and 8 include, incases where the stockholder or security holder appears upon the books of the company as trustee or in any other diduciary relation, the name of the person or corporation for whom such trustee is acting, also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner. Names and addresses of individuals who are stockholders of a corporation which itself is a stockholder or holder of bonds, mortgages or other securities of the publishing corporation have been included in paragraphs 7 and 8 when the interests of such individuals are equivalent to 1% or more of the total amount of the stock or securities of the publishing corporation.

10.

	Average No. copies each issue during Preceding 12 months	Single issue Nearest Filing Date
A. Total no. copies printed	3,203	3,135
B. Paid circulation		
1. To term subscribers by mail, carrier delivery or other means	2,895	2,413
2. Sales through agents, news dealers, or otherwise	70	70
C. Free distribution (including samples) by mail, carrier delivery, or by other means	238	238
D. Total no. of copies distributed (Sum of lines B1, B2, and C)	2,721	2,721

I certify that the statements made by me above are correct and complete.

J. P. Sanford, Managing Editor

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lossiter, Representotive
203 Porkside Building, 4140 Shelbyville Road, Louisville 7
Moiling Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884

MT. HOLLY
NURSING HOME

A Nursing Home with Hospital Standards



- *24 Hour Personal, Medical and Nursing Care supplemented by Closed Circuit Television.*
- *Balanced and Therapeutic Diets.*
- *Facilities for Orthopedic, Geriatic and Medical Patients.*
- *Leisure time activities.*

MT. HOLLY NURSING HOME

OFF BROWNSBORO ROAD **897 - 1646**

IMPORTANT NOTICE FOR DOCTORS WITH PATIENTS IN CINCINNATI HOSPITALS

SOUTHERN ARMS 'Toothbrush Apartments'



DESIGNED EXPRESSLY FOR HOSPITAL OUT-PATIENTS AND MEMBERS OF FAMILIES WHO MUST BE NEAR A HOSPITALIZED PATIENT

Completely furnished and equipped — near all major hospitals

- SHUTTLE SERVICE TO ALL HOSPITALS
- ONE BEDROOM AND EFFICIENCIES
- AIR-CONDITIONED, FREE TV
- LINEN, EATING AND COOKING UTENSILS FURNISHED
- MAID SERVICE, NURSE ON CALL, RESIDENT MANAGER
- DAILY, WEEKLY, MONTHLY RATES

Tell your patients or their relatives to see these modern, convenient, new apartments, just minutes from all major hospitals.

621-6420

SOUTHERN ARMS 2058 Auburn Ave., at Southern Avenue

CINCINNATI, OHIO

Dr. Hurt Heads Orthopedic Soc.

New president of the Kentucky Orthopedic Society is O. James Hurt, M.D., Louisville. Doctor Hurt was elected at the society meeting held on September 30 as an adjunct to the KMA Annual Meeting. Also elected at that time were Eugene Power, M.D., Lexington, vice president; and Wayne W. Kotcamp, M.D., Louisville, secretary-treasurer. Guest speaker at the scientific sessions was H. Relton McCarroll, M.D., St. Louis, Mo.

Dr. Gumbert Elected by Pilots

George M. Gumbert, Jr., M.D., Lexington, was elected president of the Flying Physicians Association at the association's annual meeting at Palm Springs, Sept. 27-Oct. 2. He will serve for one year. Membership in the association is open to licensed physicians who are members of medical societies approved by the board and who hold valid pilot's certificates. There are 22 members from Kentucky.

* * *

Liver Biopsy

Continued from Page 859

lipodiastaemate preceding experimental dietary cirrhosis, Anat. Rec. 106:61-78, 1950.
3. Schiff, L.: *Diseases of the Liver,* 2nd Ed., Philadelphia, J. B. Lippincott Co., 1963.
4. Silverman, I.: *A new biopsy needle,* Am. J. Surg. 40:671-672, 1938.
5. Franseen, C. C.: *Aspiration biopsy, with a description of a new type of needle,* New Eng. J. Med. 224:1054-1058, 1941.
6. Menghini, G.: *One-second needle biopsy of the liver,* Gastroenterology 35:190-199, 1958.
7. Terry, R.: *Risks of needle biopsy of the liver,* Brit. M. J. 1:1102-1105, 1952.
8. Conn, H. O., and Yerger, R.: *A re-evaluation of needle biopsy in the diagnosis of metastatic cancer of the liver,* Ann. Int. Med. 59:53-61, 1963.

* * *

Management of Occiput Posterior

Continued from Page 861

whom the key-in-lock maneuver was carried out.

Summary

In one thousand consecutive private patient deliveries, a previously described method of manual rotation of the posterior occiput was employed. This method was effective in 69.1 per cent of the occiput posteriors encountered.

Counter pressure at the cornua of the uterus diagonally opposite the occiput was found to greatly facilitate the maneuver.

After 92 rotations by this method, 52 per cent were allowed to deliver spontaneously.

References

1. Bill, A. H.: *The Treatment of the Vertex Occipitio-Posterior Position,* Am. J. Obst. & Gynec. 22:615 (October) 1931.
2. Danforth, W. C.: *The Treatment of Occipitio-Posterior Positions With Especial Reference to Manual Rotation,* Am. J. Obst. & Gynec. 23:360 (March) 1932.
3. McDevitt, C. J.: *The Management of Occipitio-Posterior Positions,* Ky. Medical 46:269 (July) 1948.

Dr. Hernandez Elected

C. E. Hernandez, M.D., Elizabethtown, was elected president of the Kentucky Association of Public Health Physicians at the September 29 meeting held in Louisville in conjunction with the Kentucky Medical Association's Annual Meeting.

Serving with Doctor Hernandez during the coming year will be Logan R. Campbell, M.D., Danville, president-elect; Astra U. Kidd, M.D., Brownsville, vice-president; and Mary Pauline Fox, M.D., Hazard, secretary-treasurer.

Correction

It was inadvertantly stated in the October issue of The Journal of KMA that John L. Murphy, former advertising director of the AMA and now employed by the State Medical Journal Advertising Bureau, has succeeded Alfred J. Jackson, retired. Mr. Jackson had served as president of the Bureau for many years and was succeeded by Frank L. Ramsey, M.D., Indianapolis.

Mr. Murphy is a layman (and not an M.D., as indicated in the October item) and is director of the Bureau's sales and promotion activities in the New York office of the Bureau.

Preleukemia

Continued from Page 864

2. Meacham, G. C., and Weisberger, A. S. *Early atypical manifestations of leukemia.* Ann. Int. Med. 41: 780 - 797, 1954.
3. Wintrobe, M. M. Clinical Hematology. Fifth Edition. 950 pp. Philadelphia: Lea, 1961.
4. Boggs, D. R., Wintrobe, M. M. and Cartwright, G. E. *The acute leukemias.* Medicine 41: 170 - 171, 1962.
5. Williams, M. J. *Leukemia preceded by prolonged hematologic disorder.* Blood 10: 502 - 508, 1955.
6. Rheingold, J. J., Kaufman, R., Adelson, E., and Lear, M. *Smoldering acute leukemia.* New Eng. J. Med. 268: 812 - 814, 1963.
7. Rowen, M. J. *Problems in the diagnosis of leukemia.* Ann. Int. Med. 46: 907 - 914, 1957.
8. Hamilton-Paterson, J. L. *Preleukemic anemia.* Acta Haemat. 2: 309-316, 1949.
9. Black, A. B., and Meynell, M. J. *Aleukemic myeloid leukemia presenting as aplastic anemia.* Brit. Med. J. 1: 1430-1431, 1951.
10. Manganaro, F. J. *Aplastic Anemia Preceding Acute Myeloblastic (Histiocytic) leukemia.* J. A. M. A. 173: 1559 - 1562, 1960.
11. Long, R. S., Simmons, E. E., and Schenken, J. R. *Myeloid metaplasia with terminal leukemia.* J. A. M. A. 152: 1619 - 1622, 1953.
12. Ibbott, J. W., Whitelaw, D. M. and Thomas, J. W. *The significant percentage of blast cells in the bone marrow in the diagnosis of acute leukemia.* Canad. Med. Ass. J. 82: 358 - 361, 1960.
13. Gunz, F. W., and Hough, R. F. *Acute leukemia over the age of fifty: A study of its incidence and natural history.* Blood 11: 882 - 901, 1956.
14. Dameshek, W., and Mitus, W. J. *Seven - year remission in an adult with acute leukemia.* New Eng. J. Med. 268: 870-873, 1963.

* * *

Selective Gastric Vagatomy

Continued from Page 867

2. A. Burge, H. W.; Risk, A. R.; Tompkin, A.M.B.; Barth, C. E.; Hutchinson, J. S. F.; Longland, C. J.; McLennon, I.; Miln, D. C.; *Selective Vagotomy in the Prevention of Post-Vagotomy Diarrhea.* Lancet, 2:897 (Oct.) 1961.
3. Griffith, C. A.; Stavney, L. S.; Kato, T.; Harkins, H. N.; *Selective Gastric Vagotomy,* Am. J. Surg. 105:13 (Jan.) 1963.
4. Kraft R. O.; Fry, W. J.; Ransom, H. K.; *Selective Gastric Vagotomy,* Arch. Surg. 85:687 (Oct.) 1962.
5. Johnson, F. E.; Boyden, E. A.; *The Effect of Double Vagotomy on the Motor Activity of the Human Gallbladder,* Surgery 32:591 (Sept.) 1952.
6. Wright, R. D.; Jennings, M. A.; Florey, H. W.; Lium, R.; *The Influence of Nerves and Drugs on Secretion by the Small Intestine and an Investigation of the Enzymes in Intestinal Juice,* Quarterly J. Exp. Physiol. 30:73, 1940.
7. Pfeffer, R. B.; Stephenson, H. J.; Hinton, J. W.; *The Effect of Thoraculumbar Sympathectomy and Vagus Resection on Pancreatic Function in Man,* Am. Surg., 136:505. (Oct.) 1952.
8. McGee, D. F.; Hoyama, T.; White, T. T.; *Role of Antonomic Nerves in External Secretion of Pancreas,* Fed. Proc. 21:265 (Sept.) 1962.
9. Kraft, R. O.; Fry, W. J.; *Operative Technique of Selective Gastric Vagotomy* Am. J. Surg. 105:423 (Mar.) 1963.

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients

NEW CASTLE SANITARIUM

TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses



CASE STUDIES IN OBSTETRICS AND GYNECOLOGY: by F. Jackson Stoddard, M.D.; Published by W. B. Saunders Company, Philadelphia, 1964; 312 Pages; Price, $8.50.

This fine contribution by Doctor Stoddard gives the student valuable working knowledge of the speciality of Obstetrics and Gynecology. This book, as stated in its preface, is designed to compliment and make more meaningful formal training and experience in Obstetrics and Gynecology. The case study method of instruction has proved itself repeatedly in medical school teaching. By giving individual case presentation together with discussion of them, ability to handle clinical problems is furthered.

Regimen of the management of the important complications are presented. Practically all the major problems encountered in Obstetrics and Gynecology are given in this fine presentation. I heartily recommend it to both the student and the practitioner.

JOHN W. GREENE, JR., M.D.

FUNDAMENTALS OF OTOLARYNGOLOGY, Fourth Edition: by A. R. Boies, M.D., J. A. Hilger, M.D., and R. E. Priest, M.D.; Published by W. B. Saunders Company, Philadelphia, 1964; 553 Pages; Price, $8.50.

The Preface of this book states that it is designed "to offer fundamental information to the undergraduate medical student or to the physician who is not a specialist in otolaryngology." With the recent advances in otolaryngology, this goal is difficult.

The book is unusually complete, in that most areas of modern otolaryngology have been properly recognized. This represents a major accomplishment in a text of this size.

The organization of the fourth edition is similar to that of the third. However, areas that were briefly discussed in the previous edition have been expanded and clarified.

The approach to each section is ideal, as it reviews the basic sciences as they relate to clinical situations. Pathologic states are then discussed individually from the etiology to various forms of treatment. The book reads easily, and the principles set forth are both basic and sound. The numerous drawings and illustrations enhance the often difficult relationships in question.

I believe the authors have done a fine job in presenting a basic text for the non-specialist.

GERALD D. LANDAU, M.D.

THE SPECIALTIES IN GENERAL PRACTICE, Third Edition; edited by Russell L. Cecil, M.D., and Howard F. Conn, M.D.; Published by W. B. Saunders Company, Philadelphia, 1964; 676 pages; Price, $17.50.

The vast expansion of medical knowledge has put heavy demands on the general practitioner's reading time. Only a few books are of sufficient practical value to merit his constant usage. *The Specialties in General Practice* has gained this distinction and comes as close to being a textbook of general practice as any published in this country to date.

As well known as this volume is, only a few general physicians are unfamiliar with it. Eighteen authorities have contributed component chapters which have been blended into a consistent and readible text. This is not primarily a do-it-yourself atlas: it is a review of cogent factors in the recognition and management of those diseases most frequently encountered in family medicine. That pedantic tic—to allot much space to rare conditions—is well restrained. The use of tables and illustrations is likewise limited to essential and useful topics.

To attempt to encompass such a broad field as general practice in a single book is an ambitious, if not impossible undertaking. But the reader will be astonished by one omission of the editors, one of whom is a professor of medicine and textbook author; viz., there is no chapter on common medical conditions. Despite the high value of the other portions, the busy practitioner who spends much time with ulcer, hypertensive and coronary patients will consider this a significant oversight. Further, a section of the use of the xray in diagnosis would be welcome since this is an indispensable tool in daily practice. Two chapters list essential equipment necessary for that specific field which suggests another avenue for improvement.

The name implies that only general practitioners will profit from a continuing awareness of current management of patients in all fields of medicine. Since patients' problems are seldom restricted to one specialty, however, the book will be of value to all doctors interested in remaining the "compleat physician".

HOMER B. MARTIN, M.D.



After Surgery: B and C vitamins are therapy

Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS, designed to meet increased metabolic demands, aids in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

7282-4

In Memoriam

WILLIAM F. O'DONNELL, JR., M.D.
Hazard, Ky.
1918 - 1964

William F. O'Donnell, Jr., M.D., a general surgeon and general practitioner in Hazard for 18 years, died September 24 of an apparent heart attack. A native of Richmond and a 1942 graduate of the University of Louisville School of Medicine, Doctor O'Donnell had practiced in Hazard since his release from the U.S. Army Medical Corps in 1946.

J. EDMUNDO ESTEVES, M.D.
Warsaw, Ky.
1924 - 1964

J. Edmundo Esteves, M.D., 40, Warsaw general practitioner, was killed in a September 20 automobile accident in Cincinnati. Doctor Esteves, a native of Ecuador, was his country's honorary vice-consul in the Cincinnati area. He was a 1952 graduate of the Central University Faculty of Medicine in Quito, Ecuador and had practiced on a limited license in Warsaw for three years.

JOHN PORTER WALTON, M.D.
Central City, Ky.
1882 - 1964

John P. Walton, M.D., 82, who was named Outstanding General Practitioner of the year in 1962 by the Kentucky Medical Association, and Central City's Man of the Year in 1957, died September 21 in Greenville after a long illness. Doctor Walton, who had practiced in Muhlenberg County for 55 years, graduated in 1906 from the Hospital College of Medicine in Louisville. He had retired last year.

CHARLTON A. MACPHERSON, M.D.
Louisville, Ky.
1889 - 1964

Charlton A. Macpherson, M.D., 75, who had lived in Louisville since his retirement from practice in 1954, died September 3 in Louisville. He had practiced general medicine and surgery at St. Clair, Mich. for 30 years before his retirement. Doctor Macpherson was a 1912 graduate of the University of Toronto Faculty of Medicine, Toronto, Ontario, Canada. He was a native of Ontario.

MARSHALL M. JONES, M.D.
Lexington, Ky.
1915 - 1964

Marshall M. Jones, M.D., 48, Lexington general practitioner for 20 years, died October 6 following a long illness. Doctor Jones, a 1941 graduate of Howard University School of Medicine, Washington, D.C., was a Lieutenant Colonel in the Army Reserve and a veteran of World War II. For the past three years he had served as a City physician for the city of Lexington.

ALBRO L. PARSONS, M.D.
Louisville, Ky.
1882 - 1964

Colonel Albro L. Parsons, 81, a former medical officer in the U.S. Army, died September 3 in Louisville. Colonel Parsons, a native of Louisville and a 1904 graduate of the old Louisville Medical College, practiced and taught medicine in Louisville for 12 years before becoming a medical officer. He had been retired for a number of years.

WILLIAM THOMAS JESSEE, M.D.
Plummer's Landing, Ky.
1877 - 1964

William T. Jessee, M.D., 86, who had practiced medicine in Fleming County for 50 years, died at his home at Plummer's Landing September 5 after a heart attack. Doctor Jessee, who graduated in 1902 from the Eclectic College of Medicine in Cincinnati, practiced in Rome and Portsmouth, O., and in Lewis County, Ky., before going to Fleming County. He retired from active practice in 1957.

ALVA GLENN BARTON, M.D.
Louisville, Ky.
1925 - 1964

A. Glenn Barton, Jr., M.D., 39, died September 27 at his home in Jeffersonville, Ind. Doctor Barton, a general practitioner, was graduated in 1960 from the University of Louisville School of Medicine. A native of Memphis, Tenn., he was a veteran of World War II.

MURFREESBORO - VACANCIES: STAFF PHYSICIANS for 1275 bed neuropsychiatric hospital, including 350 general medical and geriatric. Modern facilities for diagnosis and treatment of mental illness. Salary $11,150 to $18,405 depending on qualifications; fringe benefits; cost of moving to Murfreesboro will be paid by Veterans Administration; visit here for evaluation can be arranged at our expense. Excellent educational opportunities for students in this area. Contact Director, Veterans Administration Hospital, Murfreesboro, Tenn.



"Gesundheit!"

...is just for the sneeze

but for symptomatic relief of the common cold...

'EMPRAZIL'®

TABLETS

Each layered tablet contains:

'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

To relieve the aches, pains, fever and respiratory congestion of the common cold, flu or grippe with one product ...specify 'Emprazil'.

Caution: While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed.

Supplied: Bottles of 100 and 1000.

Also available with codeine—on prescription only—as 'EMPRAZIL-C'® tablets

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

KENTUCY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1964-1965

Officers

DELMAS M. CLARDY, 901 ½ East Main Street, Hopkinsville ..... President
EVERETT H. BAKER, 1169 Eastern Parkway, Louisville ..... President-Elect
GEORGE P. ARCHER, Prestonsburg ..... Immediate Past President
ROBERT W. LYKINS, Louisville ..... Vice President (Central)
HAROLD B. BARTON, Corbin ..... Vice President (Eastern)
KENNETH M. EBLEN, Henderson ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, CORBIN ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
ROBERT PENNINGTON, London ..... Chairman of the Board of Trustees
DONALD CHATHAM, Shelbyville ..... Vice Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

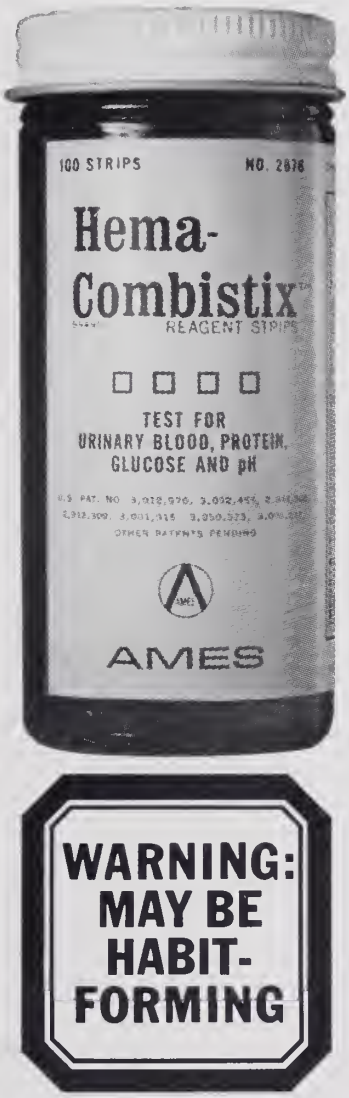
Trustees

First District ..... O. LEON HIGDON, 2515 Broadway, Paducah 1965
Second District ..... W. GERALD EDDS, Calhoun 1967
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville 1967
Eighth District ..... W. DONALD JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1967
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1967
Eleventh District ..... HUBERT C. JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... WALTER L. CAWOOD, Kings Daughters Hospital, Ashland 1967
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

Buyers Guide

JOURNAL OF THE KMA BUYERS GUIDE FOR NOVEMBER, 1964

Ames Company 913
Burroughs Wellcome 911
Coca-Cola Company 846
Geigy Pharmaceuticals 890
Glenbrook Laboratories 848
J.J.B. Hilliard & Sons 903
The Keeley Institute 898
Lederle Laboratories 829-842-882-883-897-909
Eli Lilly 852
Medical Protective Company 905
Wm. S. Merrell Company 834-835
Mt. Holly Nursing Home 905
New Castle Sonitarium 907
Emerson A. North Hospital 843
Parke, Davis & Company 828
Pfizer Laboratories 847-849-850-851
Wm. A. Poythress & Company 844
A. H. Robins Company 837-838-839-899-900-901
Roche Laboratories 914
G. D. Searle & Company 883
Smith Kline & French 845
Southern Arms Apartments 906
Southern Optical Company 846
V. A. Hospital 910
Wallace Laboratories 833-841-888-889
Winthrop Laboratories 831



Once you have used **HEMA-COMBISTIX,**™ dip-and-read test for urinary blood, protein, glucose, and pH, it may become a habit to test every patient's urine routinely with this simple, convenient reagent strip. Most of the answers will be "negatives," but an unexpected "positive" may alert you to serious pathology even before related symptoms appear. The test takes only 60 seconds. As basic as the stethoscope...**HEMA-COMBISTIX** is a *good* habit to form. □ Ames Company, Inc., Elkhart, Indiana. 68764

AMES

AMES



for
The Age of
Anxiety

In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. *Cautions*—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment. *Supplied*—Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.

LIBRIUM®
(chlordiazepoxide HCl)

ROCHE

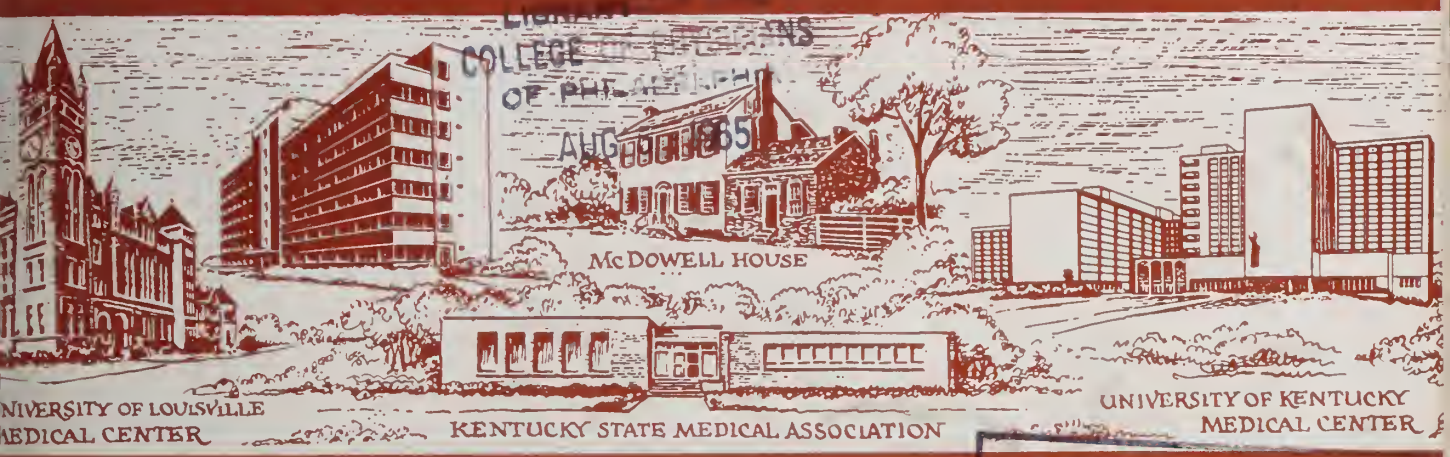
Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, N.J. 07110

DECEMBER 1964 • VOLUME 62 • NUMBER 12

Season's Greetings

THE JOURNAL

OF THE KENTUCKY MEDICAL ASSOCIATION



COLLEGE OF PHYSICIANS
AUG 1965
LEE

In This Issue

Surgical Management of Inflammatory Lesions of the Pancreas
Rene Menguy, M.D. 937

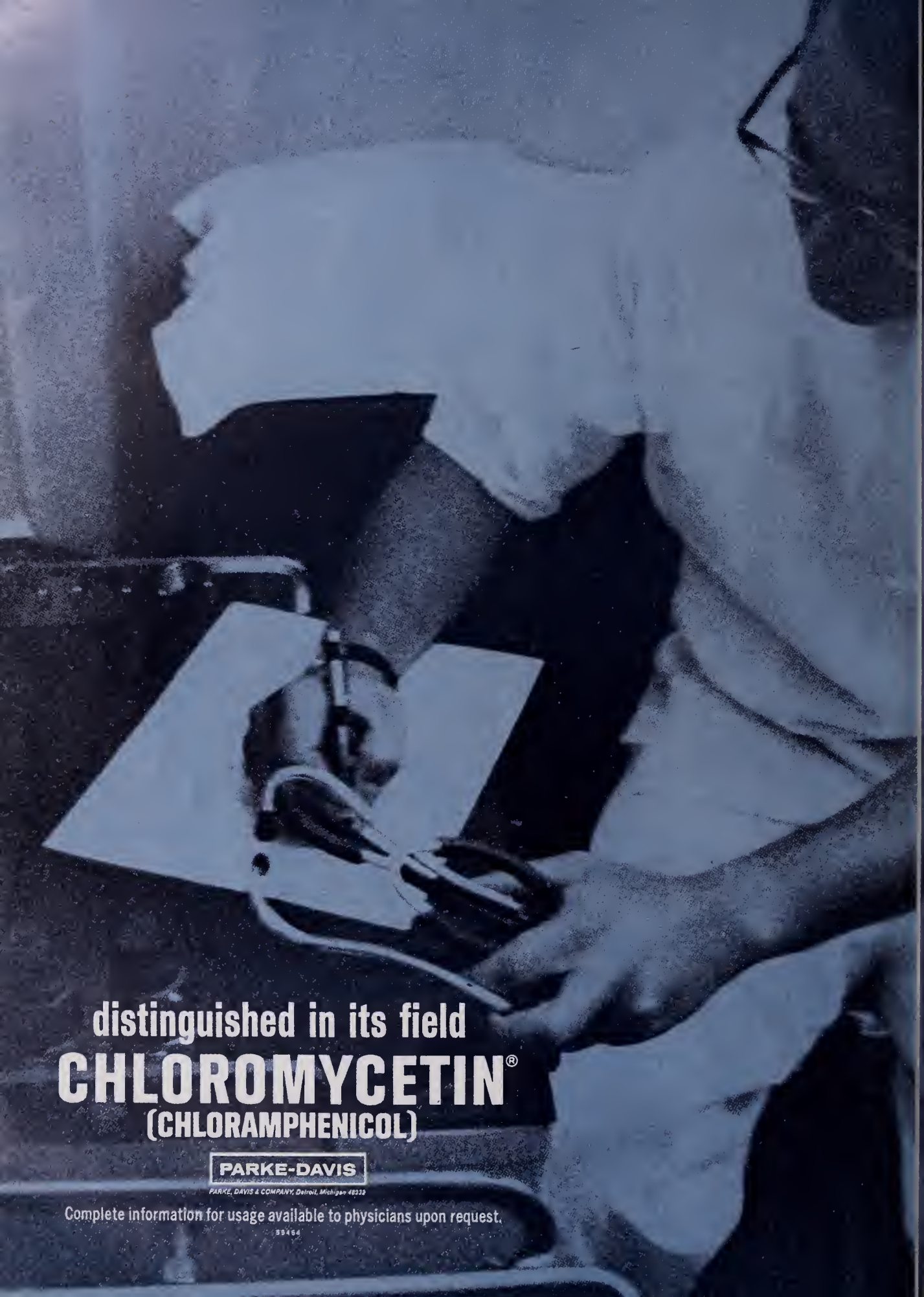
Appendicitis in Pregnancy
Thomas H. Baker, M.D. 944

Role and Contributions of the Psychiatrist in Private Practice
Hollis Johnson, M.D. 947

Sudden, Unexpected Death in Infancy
Daniel Stowens, M.D., Edward Callahan, M.D., and Jennifer Clay, M.D. 949

Complete Contents on Page 918

KMA 1965 Interim Meeting — March 18
Gabe's Restaurant, Owensboro


distinguished in its field
CHLOROMYCETIN®
(CHLORAMPHENICOL)
PARKE-DAVIS
PARKE, DAVIS & COMPANY, Detroit, Michigan 48232
Complete information for usage available to physicians upon request.
39464

Announcing . . . the Second Volume in the New Series from SAUNDERS

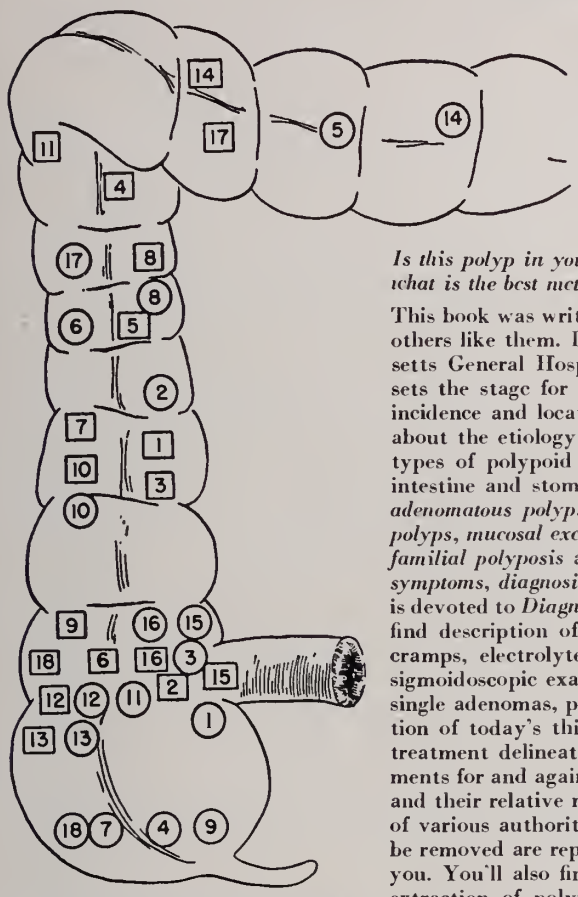


Figure 3-25. *Location of cancer and simple adenomas in resected cancers of the right colon. Squares locate cancers; circles, adenomas.*

Polypoid Lesions of the Gastrointestinal Tract

by Claude E. Welch, M.D.

Is this polyp in your patient benign or malignant? Should it be removed? If so, what is the best method for this particular lesion in this particular patient?

This book was written to help you answer questions such as those above, and others like them. Its author has drawn on the experience of 1124 Massachusetts General Hospital patients, plus many personal cases. Dr. Welch first sets the stage for a fruitful discussion by defining terms, by discussing the incidence and location of polypoid tumors, and summarizing what is known about the etiology of adenomas. He then proceeds to illuminate the various types of polypoid lesions you'll encounter in the colon and rectum, small intestine and stomach. He describes and illustrates common lesions such as *adenomatous polyps* and *papillary adenomas*, and such rare ones as *pseudopolyps, mucosal excrescences, Peutz-Jeghers polyps*, etc. *Multiple polyposis* and *familial polyposis* are also completely covered. *Etiology, incidence, pathology, symptoms, diagnosis, prognosis, treatment*, are clearly set forth. A full chapter is devoted to *Diagnosis of Polypoid Lesions of the Colon and Rectum*. Here you'll find description of symptoms (bleeding, change in bowel habit, abdominal cramps, electrolyte imbalance, etc.) and physical findings from palpation, sigmoidoscopic examination, and radiologic examination. The relationship of single adenomas, papillary adenomas, and cancer is discussed, with examination of today's thinking on the adenoma-cancer relationship. A chapter on treatment delineates location and identification of polyps, giving you arguments for and against their removal. Polypectomy and resection are discussed and their relative merits contrasted. If resection is decided upon, the opinion of various authorities as to the amount of bowel and mesentery that should be removed are reported. The author states his own conclusions to help guide you. You'll also find helpful consideration of sub-total and total colectomy, extraction of polyps via the anus, posterior proctotomy, resection of the rectum, and sigmoidoscopic removal of polyps.

By Claude E. Welch, M.D., Visiting Surgeon, Massachusetts General Hospital, Boston; and Clinical Professor of Surgery, Harvard Medical School, Boston. 148 pages. 6⅛" x 9¼", illustrated. $7.50. *New—Just Ready!*

About this New Series: MAJOR PROBLEMS IN CLINICAL SURGERY

J. Englebert Dunphy, M.D., Consulting Editor

Each volume in this series will exhaustively illuminate a significant and pressing problem met in surgical practice by the clinical surgeon. These monographs aim to fill the vital gap left between standard textbooks of surgery and relevant journals. Held to a consistently graduate level of presentation, they give rock-solid accounts and analysis of precisely what can be done today in managing knotty surgical problems. Each eminently qualified specialist-author will present a critical analysis of changing approaches to therapy, of etiology, pathologic physiology, diagnosis and differential diagnosis. Where operative techniques figure importantly in the problem, they will be clearly described and fully illustrated in abundant detail. Operative and postoperative complications, results and prognosis will be carefully considered; areas of conflict in theory and hypothesis fully explored. The authors' own evaluations, opinions and conclusions will be expressed and substantiated. Several volumes will appear each year, containing between 150-300 generously illustrated pages.

Child—*The Liver and Portal Hypertension*, was the first volume in this series, published June, 1964. Future volumes are scheduled to cover: *Trauma to the Liver—Surgical Problems of the Pancreas—Peripheral Arterial Disease.*

Why not subscribe to the entire series on an automatic, full return privilege basis? You need merely check the proper square below to see each one of the series on examination. Sent postpaid.

W. B. SAUNDERS COMPANY
West Washington Square, Phila., Pa. 19105

Please send and bill me:

☐ Welch—*Polypoid Lesions*____$7.50

☐ Enter my series subscription

☐ Begin with *Child* $8.50 ☐ Begin with *Welch*

Name_____

Address_____

SJG 12-64

VOLUME 62 • DECEMBER 1964

JOURNAL of the KENTUCKY MEDICAL ASSOCIATION

Contents

of the Board of Trustees

• EDITOR
Sam A. Overstreet, M.D.

• ASSOCIATE EDITOR
Walter S. Coe, M.D.

• MANAGING EDITOR
J. P. Sanford

• ASST. MANAGING EDITOR
Ann M. Huntsman

• DEPARTMENTAL EDITORS
Jack L. Chumley, M.D., Scientific
Eugene H. Canner, M.D., Book Reviews
Oscar J. Hayes, Case Discussions
W. Vinson Pierce, M.D., Insurance

• ADVISORY COMMITTEE TO THE EDITOR
Blaine Lewis, Jr., M.D., Chairman
Patrick J. Murphy, M.D.
Gerald B. Reams, M.D.
Willett H. Rush, M.D.
Frederick Scott, M.D.
Orson P. Smith, M.D.

• BOARD OF CONSULTANTS ON SCIENTIFIC ARTICLES

Term Expires July 1, 1967
Edward C. Groves, M.D.
Carl W. Kumpe, M.D.
Marvin A. Lucas, M.D.
Robert N. McLeod, Jr., M.D.
Henry W. Post, M.D.
Clinton R. Potts, M.D.
Oscar Thompson, M.D.
George I. Uhde, M.D.

Term Expires July 1, 1966
Harold L. Bushey, M.D.
Edward J. Fodell, M.D.
Merle W. Fowler, Jr., M.D.
Joseph L. Goldstein, M.D.
John D. Lovett, M.D.
George F. McAuliffe, M.D.
Ralph G. Thomas, M.D.
Eugene Todd, Jr., M.D.

Term Expires July 1, 1965
McHenry S. Brewer, M.D.
Lewis Dickinson, M.D.
Zygmunt Gierloch, M.D.
Douglas L. Gillim, M.D.
Arthur H. Keeney, M.D.
James B. Stith, M.D.
Chester B. Theiss, M.D.
Kearns R. Thompson, M.D.

Published: 3532 Janet Avenue, Louisville, Ky. 40205

Subscription $8.00—single copy .80

Second-class postage paid at Louisville, Kentucky. Acceptance for mailing at special rates postage provided in Section 1103, act of Oct. 3, 1917, authorized May 25, 1920.

SCIENTIFIC ARTICLES

Surgical Management of Inflammatory Lesions of the Pancreas
Rene Menguy, M.D. 937

Appendicitis in Pregnancy
Thomas H. Baker, M.D. 944

Role and Contributions of the Psychiatrist in Private Practice
Hollis Johnson, M.D. 947

Sudden, Unexpected Death in Infancy
Daniel Stowens, M.D., Edward Callahan, M.D., and Jennifer Clay, M.D. 949

SPECIAL ARTICLE

Fifty Years in the Practice of Medicine in Georgetown
Harry V. Johnson, M.D. 954

EDITORIALS

Thanks 956
In Flanders Fields 957

FEATURES

Digest of Proceedings, 1964 House of Delegates Meeting 959
KMA Constitution and Bylaws 1039
Index of The Journal for 1964 1049

ORGANIZATION SECTION

1965 KMA Interim Meeting Set for March 18 at Owensboro 1016
Fifth District to Meet Jointly with Fourth and Seventh 1016
Ky. Physicians' Mutual Board Elects Dr. Rust President 1016
Ky. Assn. of Registered Nurses Elects Mrs. Nadine Turner 1017
Norton Seminar Set for December 17 in Louisville 1017
Ky. Pair Take Part in Congress on Mental Health 1017
New AMA Field Representative for Ky. is State Native 1018
Ky. Medical Assistants Attend National Meeting October 13-18 1018
Dr. Cutthoff Elected Chairman of Ky. Rural Health Council 1018
Graphs Depict Distribution of KMA Finances 1018
U.L. Accepts Gifts and Grants of $282,582 for Med. School 1022
U.K. Med. Center Names New Orthopedic Surgery Chief 1022
Cincinnati Medical Historians Visit McDowell House 1025

REGULAR FEATURES

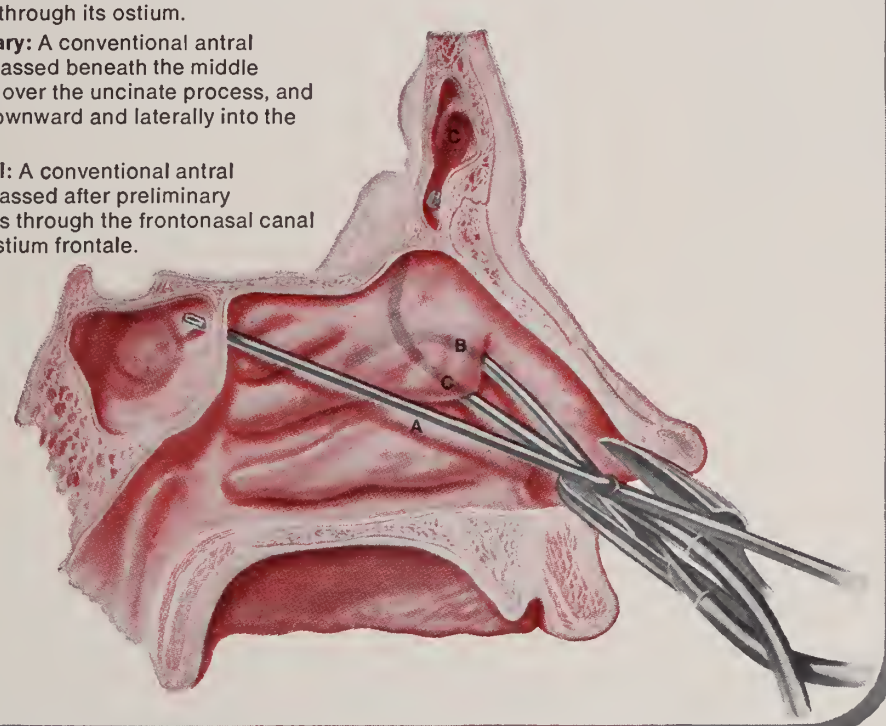
President's Page 920
Insurance Page 924
In The Books 932
Answers to Blue Shield Questions 1024
Postgraduate Opportunities 1028
Maternal Mortality Page 1030

A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

C—Frontal: A conventional antral cannula passed after preliminary maneuvers through the frontonasal canal into the ostium frontale.



In colds and sinusitis

Neo-Synephrine sooner

hydrochloride
(Brand of phenylephrine hydrochloride)

can help prevent emergency measures later

Before complications arise in colds and sinusitis, Neo-Synephrine solutions and sprays reduce nasal turgescence on contact — to promote essential aeration and drainage. Turbinates shrink, sinus ostia open and drainage is freed. Relief is instant and the threat of complications is lessened.

In the treatment of sinusitis, the ¼ per cent solution is a preferred vasoconstrictor, "... most closely approximating physiologic composition with the least 'rebound' tendency...."* Gentle Neo-Synephrine is well tolerated by delicate respiratory tissues. Systemic effects are practically nil, post-therapeutic turgescence is minimal and repeated applications do not lessen its effectiveness. Neo-Synephrine has been a standard among vasoconstrictors since 1935.

Available in plastic nasal sprays for adults (½%) and children (¼%), in solutions of ⅛, ¼ or 1 per cent.

*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

Winthrop Laboratories
New York, N. Y. Winthrop

(1839M)

MESSAGE FROM THE PRESIDENT



What Is Your Motivation?

AS the Christmas Season approaches "Peace on Earth and Good Will toward Men" will be used with increasing frequency. This quotation, translated into love for your fellow-man, can be the motivation for vocations in life. This season is an excellent time for self-appraisal, not in a critical manner, but an honest inquiry of why you are a physician.

A desire to be of service to others is the motivation of everyone living in dignity. Healing is the desire for the physician; truth for the scientific researcher; beauty for the artist, education for the dedicated teacher; religion for the minister. The list is endless. The bond that unites these vocations to the individual is the unselfish, altruistic character and noble desire to give something, which, in the final analysis, is love. Without this desire, life would be lacking in meaning, purpose and joy of living.

Other motivations may begin as desires for prestige, fame, social status and fortune. Many become physicians because of one or more of these factors, but whatever the force that originally drove us to cross the threshold of the Temple of Aesculapius to follow the code of Hippocrates, the vocation of love of services to our fellow-man most often prevailed. What started as selfish desires ended in true dedication.

Despite the poisonous criticisms that have been aimed at physicians throughout the ages, medicine is still the only profession nourished by the dream of service and creation—serving the sick and creating health. Each physician has a dream as characteristic and identifying as his own fingerprints—of what, for him, is the best way of being a doctor and fulfilling with dignity and greatness the task of his profession.

Medicine is truly the great vocation. It exemplifies always "Peace on Earth and Good Will toward Men." May it never be otherwise.

Delman M. Eberly



following infection

STRESSCAPS B and C vitamins in therapeutic amounts...help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS.

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY Pearl River, N.Y.

8693 4

Lederle


for the
patient with
'pain &
spasm'

pain is almost invariably a presenting symptom in cases of skeletal muscle spasm

In some instances, the pain subsides on relaxation of the muscles in spasm. In others, relaxant therapy alone fails to give adequate relief, and supplementary analgesia (and possibly sedation) are indispensable, as in cases of:

provocative pain, when muscle spasm is triggered by some painful underlying musculoskeletal defect.

residual pain, when relaxation of severe spasticity leaves a degree of myalgia that tends to reinvoke spasm.

severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

emotionally aggravated pain, when anxiety or agitation creates tension that thwarts the efficacy of both relaxant and analgesic medication.

In such cases, ROBAXISAL and ROBAXISAL-PH have proven highly effective in assuring decisive and comprehensive relief. The ROBAXISAL formula—of ROBAXIN (methocarbamol), the potent muscle relaxant, together with aspirin, the time-tested and proved analgesic—produces higher plasma salicylate levels than equivalent doses of aspirin alone, and serves effectively to control both spasm and pain. ROBAXISAL-PH's combination of ROBAXIN (methocarbamol) with the analgesic-sedative ingredients of the PHENAPHEN formula—including phenobarbital—helps additionally to ease apprehension.

ROBAXISAL®

Robins

Each pink-and-white laminated Tablet contains:
ROBAXIN (methocarbamol, Robins) ..... 400 mg. Aspirin (5 gr.) ..... 325 mg.
U.S. Pat. No. 2770649

ROBAXISAL®-PH

Each green-and-white laminated Tablet contains:
ROBAXIN (methocarbamol, Robins) ..... 400 mg.
Phenacetin (1½ gr.) ..... 97 mg.
Aspirin (1¼ gr.) ..... 81 mg.
Hyoscyamine sulfate 0.016 mg.
Phenobarbital (⅛ gr.) ... 8.1 mg.
(Warning: May be habit forming)



"PAIN & SPASM"
—a two-headed dragon!

ROBAXISAL and ROBAXISAL-PH are indicated in strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

Side effects such as lightheadedness, slight drowsiness, dizziness and nausea may occur rarely in patients with intolerance to drugs, but they usually disappear on reduction of dosage.

Contraindicated for patients hypersensitive to any component of the formulations. There are no specific contraindications to methocarbamol, and untoward reactions are not to be expected.

A. H. ROBINS CO., INC., Richmond 20, Virginia



THE INSURANCE PAGE



Five Important Years

FIVE YEARS AGO, the Editor and his Advisory Committee of The Journal of the Kentucky Medical Association instituted a new editorial feature, devoted to information concerning voluntary health insurance and prepayment. It has been our privilege to serve as the first editor of the Insurance Page.

This has been a task which we have enjoyed, since it is our conviction that the financing of health care through voluntary prepayment is a sine qua non in the preservation of our present system of medical practice in this country. It is most important, therefore, that all of our physicians be well informed concerning the various types of health insurance available to their patients.

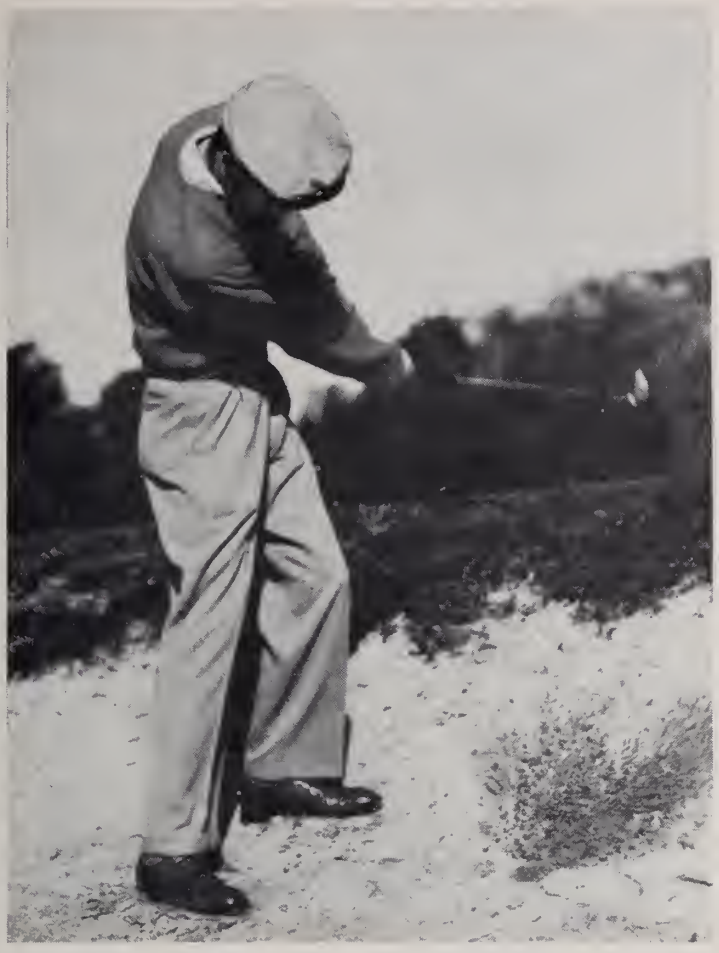
The time has come when we feel that it is advisable for us to relinquish the duties of this editorship to someone else. We are happy to know that the editors of The Journal have selected William W. Hall, M.D., of Owensboro, for this position.

Doctor Hall is deeply devoted to the philosophy of voluntary prepayment as the best means of financing health care for most of our people, and he is very knowledgeable in this area. Under his guidance the Insurance Page will become an increasingly valuable source of information for our Kentucky physicians.

To the editors of The Journal, who have been so kind to us; to the assistant editors, who have been patient with our tardiness in submitting copy on some occasions, and to the many individuals who have contributed to this page, we express our sincere appreciation. In the latter regard, the members of the staff of Kentucky Physicians Mutual have been especially helpful.

Most of all, we are grateful to those readers of The Journal who have taken the time to peruse our editorial efforts. We have enjoyed these five years—we hope that you have!

W. VINSON PIERCE, M.D.



Your patient doesn't have to be in the Masters to get sprains and strains

Regardless of the etiology of muscle sprain or strain, 'SOMA' COMPOUND helps relieve pain and relax muscle. Patient comfort can be increased and recovery time shortened.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

rational combination therapy for sprains and strains: relaxes muscle, relieves pain. Also available with ¼ gr. codeine as 'SOMA' COMPOUND with CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

BRIEF SUMMARY
'SOMA' COMPOUND; 'SOMA' COMPOUND plus CODEINE: carisoprodol, acetophenetidin, caffeine, codeine phosphate. *Warning: Codeine may be habit-forming.* **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are indicated for relief of pain and stiffness in traumatic, rheumatic and other similar conditions. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol or codeine. **Precautions:** *Acetophenetidin*—May damage the kidneys when used in large amounts or for long periods. *Codeine*—Should be used with caution in addiction-prone individuals. *Carisoprodol*—Like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate. **Side effects:** *Codeine*—Nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is drowsiness, usually on higher than recommended doses. One instance each of pancytopenia and leukopenia occurring when carisoprodol was administered with other drugs has been reported as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. Other rarely observed reactions have included dizziness, ataxia, agitation, increase in eosinophil count, and gastrointestinal symptoms. Massive overdosage may produce coma and/or mild shock and respiratory depression. **Dosage:** 'Soma' Compound and 'Soma' Compound with Codeine, one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white, lozenge-shaped tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

CSO-3518

WALLACE LABORATORIES
Cranbury, N. J.

too young to be so tired...





revive interest... restore activity promptly with

Alertonic®

Three tablespoonfuls (45 cc.) contain:		
Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age

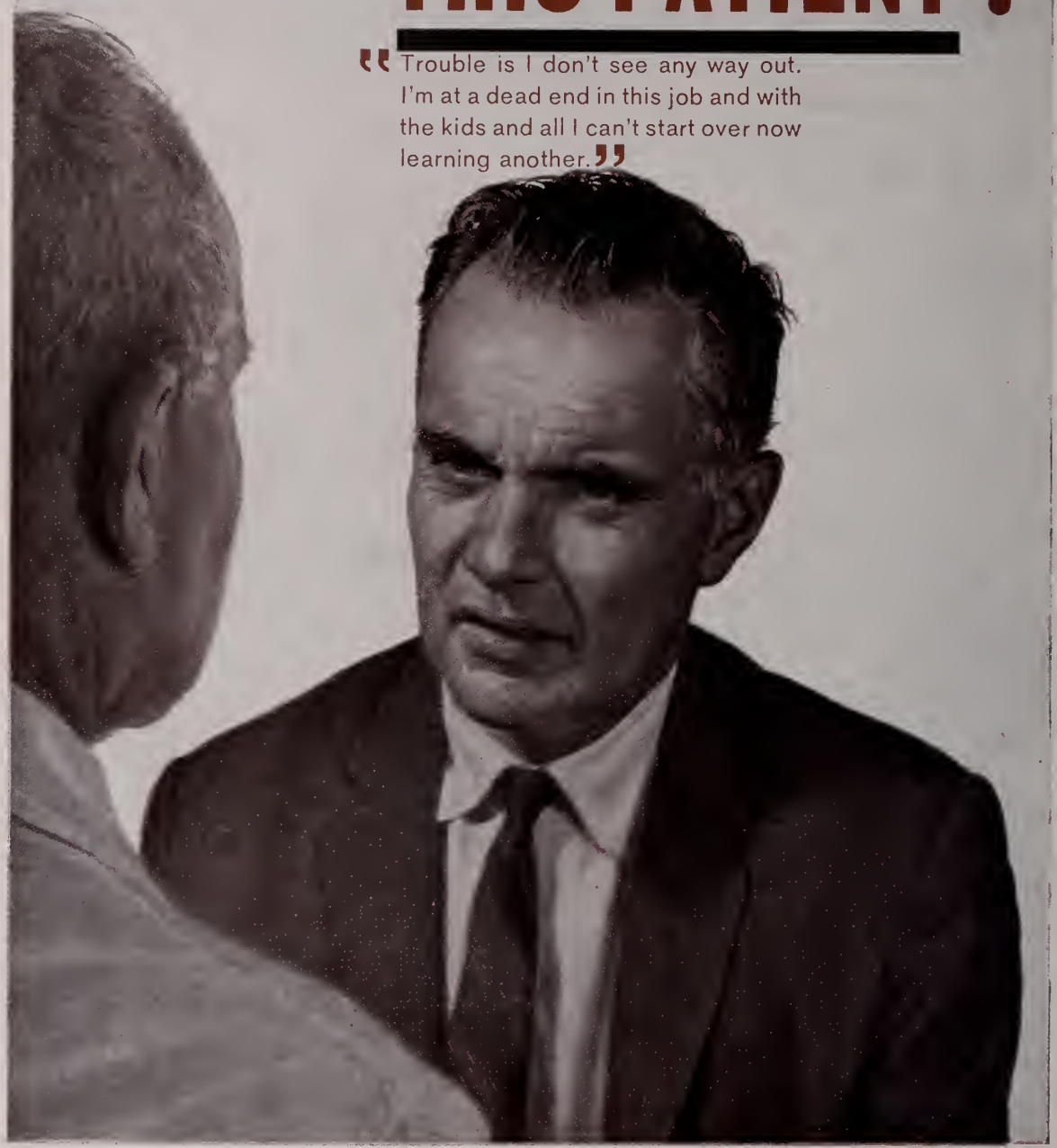
Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ... available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio / Weston, Ontario

RECOGNIZE THIS PATIENT?



Indications: Depression, both acute (reactive) and chronic, especially when the depression is accompanied by anxiety, insomnia, and related symptoms. **Contraindications:** Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal **Side effects:** Side effects associated with 'Deprol' have consisted primarily of drowsiness and occasional dizziness, and infrequent skin rash and nausea. *Benactyzine hydrochloride* – Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

When you recognize depression and anxiety traceable to an emotionally charged situation with no somatic disorder

—*start the patient on 'Deprol'*

Typical situations in which 'Deprol' is indicated:

marital or other family problems ■ death of a loved one ■ financial worries ■ fear of cancer, heart disease or other life-threatening illness ■ pre- and post-operative apprehensions ■ retirement problems, and many other stressful situations which cause the patient to feel a sense of loss, guilt or unworthiness

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' restores normal sleep, relaxes physical tensions, and improves appetite.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is relatively nontoxic and free of side effects.
5. When depression and anxiety accompany physical illness, 'Deprol' is compatible with drugs used to treat these organic conditions.

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-3561

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis, and anaphylaxis. Treatment should be symptomatic and the drug not reinstituted. Isolated cases of agranulocytosis and thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. **Dosage:** Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and reduced gradually to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients. **Supplied:** Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg. *Before prescribing, consult package circular.*

Season's Greetings

To Our 1964 Advertisers

AS THE old year draws to a close, we on the staff of The Journal would like to express our appreciation for the support which *you,* our advertisers, have given us during 1964.

WE ARE grateful for your valuable contribution to The Journal of KMA during the past twelve months—and with your help, look forward to making our Journal more attractive, useful and readable in the coming year.

TO EACH of you, our advertisers, we would like to extend our very best wishes for a happy holiday season and prosperity in the New Year.

The Editor and Staff
The Journal of KMA

Ames Company, Inc.
Baker Laboratories
Blue Cross Hospital Plan, Inc.
Burroughs Wellcome & Co., Inc.
Chothom Pharmoceuticols, Inc.
Coco-Cola Company
Chicago Medical Society
City View Sonitarium
Clevelond Clinic Educotionol Foundotion
Corn Products Company
E. L. Dennis, M.D.
Downtown Louisville Monagement, Inc.
E. I. DuPont DeNemours & Company
Endo Loborotories
Fairmount Clinic
First Texas Pharmoceuticols, Inc.
Geigy Phormaceuticals
Glenbrook Loboratories
Hort Laborotories
J.J.B. Hilliard
Jewish Hospitol of St. Louis
Mourice Koufman, M.D.
The Keeley Institute
KEMPAC
William Kendrick Jewelers
Kentucky Hotel
Kentucky Tuberculosis Association
Doctors King, Morrow, ond Associotes
Lederle Loborotories
Leeds Memorial Clinic Associotion
Eli Lilly ond Company
Louisville Heart Associotion
Madison Stote Hospitol
J. O. Mottox, M.D.
The Medical Protective Company
Medco Electronics
William S. Merrell Company
Mt. Holly Nursing Home, Inc.
New Castle Sonitorium
Emerson A. North Hospitol
Parke Dovis & Company
Mrs. A. J. Pouli
Pfizer Loboratories
Pharmaceuticol Manufocturers Association
Phoenix Assurance Company of New York
Physicions Mutuol Insurance Company
William P. Poythress & Company
A. H. Robins Company
Roche Loboratories
J. B. Roerig ond Company, Inc.
William H. Rorer, Inc.
W. B. Sounders Company
Schering Corporotion
Cloyton L. Scroggins Associates
G. D. Seorle ond Company
L. J. Singermon, M.D.
Smith Kline & French Loborotories
Southern Arms Apartments
Southern Opticol Company
E. R. Squibb ond Sons
M. R. Thompson, Inc.
Union Corbide Chemicals Company
The Upjohn Company
Vanderbilt University
Veterons Administrotion Hosp., Lexington, Ky.
Veterons Administration Hosp., Murfreesboro, Tenn.
Wolloce Loborotories
Winthrop Laborotories

why does 150 mg.



do more than 250 mg.



of other tetracyclines?

Because it has up to 3½ times the *in vitro* antibacterial activity[1]...combined with lower rate of decay in serum, slower renal clearance...a favorable depot effect, resulting from protein binding...all providing rapid, higher and sustained *in vivo* activity with as much as 2 days' extra activity.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. **Side Effects** typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative *in vitro* Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

7516-3

Lederle

IN THE BOOKS

CURRENT THERAPY, 1964; edited by H. F. Conn, M.D.; Published by W. B. Saunders Co., Philadelphia, 1964; 797 pages, price, $13.00.

This is the 16th edition of a well-known annual volume which is of great value to medical practitioners. As in the past, the topics covered are extensive but not exhaustive. Each chapter is prepared by an individual of recognized competence. It is a virtue of this series that the topics and points of view of the authors vary from volume to volume so that a well-rounded coverage of controversial areas is obtained over a period of time. A case in point is the therapy of hyperthyroidism, this year the surgical point of view is stressed. A medical program for treating peptic ulcers is well presented.

A table of normal laboratory values is printed on the inside face of both covers. The extensive section on pediatric dosages is very useful. A valuable section on poisons describes not only the treatment of specific poisons but also lists the Poison Control Centers in the United States and the types of poisonous substances present in various common household items.

The print and paper are excellent and well able to withstand the use this volume deserves and will get.

E. Douglas Rees, M.D.

EMERGENCY TREATMENT AND MANAGEMENT, Third Edition: by Thomas Flint, Jr., M.D.; Published by W. B. Saunders Co., Philadelphia, 1964; 686 pages, price, $8.75.

The third edition of Dr. Flint's book is a most current, complete, and comprehensive treatise of the subject, "Emergency Treatment and Management," presented in outline form pleasantly devoid of verbiage.

The subject matter is well grouped together for rapid and easy identification.

The author devotes 182 pages to the care of poisoning, presenting the subject in a precise step-by-step manner of treatment with an excellent cross reference, when needed.

The procedure to follow when confronted with emergency situations is brief and factual. The author also states in an equally lucid manner what not to do. This is equally important.

The medical-legal aspects of emergency treatment are very clearly portrayed.

The fact that the index and cross reference system is so complete adds to the value of this edition for a quick reference in emergency care.

Should one need a manual to help him remember what to do in the care of an emergency, this book will furnish the desired information quickly and accurately.

Hobart D. Belknap, M.D.

TEXTBOOK OF PEDIATRICS, Eighth Edition: edited by Waldo E. Nelson, M.D.; Published by W. B. Saunders Co., Philadelphia, 1964; 1636 pages, price, $18.00.

Twenty years ago Dr. Waldo Nelson "reluctantly" took over the editorship of this internationally famous major text on pediatrics. That was the fourth edition and now we have the eighth.

It must be rare for such a book and its sequential editions to have always sequentially improved also, and not to have grown and grown in size out of all proportions. Now the eighty-five contributors, who read as a Who's Who in Pediatrics, have again been guided and brought together to produce this, the finest edition so far.

The eighth edition has been revised and brought up-to-date and published in a short time—an important consideration in a constantly developing and changing specialty. Particularly is this so in the field of peri-natal factors and disease.

The Saunders Company are rightly proud of this major text; what a long and happy marriage they have had with Dr. Waldo Nelson. The book is, of course, a must for any centre or individual concerned with pediatrics.

I have one complaint: Dr. Nelson's daughters have always helped (from the time they could read) with the publication of the editions. In the seventh, being responsible for and exhausted in the preparation of the Index, they managed to insert in it, entirely missed by publisher and editor, the delightful item: "Birds, for the, pages 1-1413". The book was 1413 pages long. This filial barb has been eliminated. The Nelson warmth and scholarship is, however, still there.

Frank Falkner, M.D.



The discharged mental patient . . . and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. 27:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

SK&F *Smith Kline & French Laboratories*

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

LOUISVILLE OFFICE: Riley Lassiter, Representative
203 Parkside Building, 4140 Shelbyville Road, Louisville 7
Mailing Address: P.O. Box 20065, Louisville 20
Office Phone: TWinbrook 5-5501 • Residence Phone: ANdrews 7-5884

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 1, 2, 3 and 4, 1965

Palmer House, Chicago

THIS CONFERENCE IS DESIGNED TO BE OF INTEREST TO ALL PHYSICIANS. It is not sectionalized by medical specialties, but by types of disease entities. These will be presented in a manner designed to interest the generalist and specialist alike. All physicians, regardless of their principal areas of practice, should find much in this program which will be informative and useful.

For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
310 So. Michigan Ave.
Chicago, Illinois 60604



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

313-4



and it's not a once-over-lightly one, either. All rubber stoppers used in Lilly ampoules are scrupulously cleaned with a detergent and hot deionized water in a special washing machine like the one pictured above. This removes any foreign matter adhering to them. Then the stoppers are autoclaved at 120° to 121°C. for one hour. They are now clean, sterile, and ready for use. In case the stoppers are not used within seventy-two hours, they are returned for resterilization. □ This meticulous process is only one of the many safeguards to insure the quality of the finished product and to protect the ultimate user.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

401196

The JOURNAL of the
Kentucky Medical Association

Issued Monthly Under The Direction Of The Board Of Trustees

VOLUME 62 December, 1964 No. 12

Surgical Management of Inflammatory Lesions of the Pancreas†*

Rene Menguy, M.D., Ph.D., F.A.C.S.**
Lexington, Ky.

Acute pancreatitis is often related to alcoholism and gallstones. Although this condition is best treated conservatively, its diagnosis may require laparotomy to exclude other potentially surgical conditions. The complications of acute pancreatitis are best treated surgically.

THE conditions included in this discussion are acute pancreatitis and its sequellae: pancreatic pseudocyst, pancreatic abscess and chronic pancreatitis.

Etiology

The etiology of acute pancreatitis remains to be clarified. Since Opie's original description[1] of a gall stone impacted in the ampulla of Vater causing reflux of bile into the pancreatic duct, bile reflux has often been invoked to explain the etiology of acute pancreatitis. However, this occurrence is a pathological rarity and its importance as an etiological factor is doubtful because of studies showing that bile reflux is of little consequence.[2] Probably the most important factor in the genesis of acute pancreatitis is pancreatic ductal obstruction[3] from a stone, from spasm of the sphincter of Oddi or in rare instances by an adenocarcinoma of the head of the pancreas. Other possible etiological mechanisms are changes in pancreatic blood flow and a local auto-immune reaction. Pancreatic trauma resulting either from a blow to the epigastrium or from pancreatic injury during gastric surgery is an occasional cause of acute pancreatitis. Whatever the intimate mechanism may be, the essential change taking place during an attack of acute pancreatitis is an egress of pancreatic juice containing active proteolytic enzymes into the interstitial tissues of the pancreas and thence into the peripancreatic tissues causing in its passage severe inflammation and hemorrhage.

Although there is no good explanation for this relationship, it is well known that chronic alcoholism or chronic cholecystitis is associated with approximately 90% of cases of acute pancreatitis. In some centers the incidence of associated alcoholism approaches 100%.

Clinical Manifestations

The salient clinical manifestation of acute pancreatitis is epigastric pain. Characteristically, the pain radiates to the back and may be relieved by placing the patient in the sitting position. Patients often discover this by themselves and adopt a kneeling position in bed. Frequently the pain is so rapid in onset that it may be characterized as apoplectic. Although extremely severe attacks are accompanied by some

†*Presented at the September 25 meeting of the Kentucky Chapter, American College of Surgeons, during the 1963 KMA Annual Meeting in Lexington.*

**Supported in part by the Fred Rankin Surgical Fund.*

***Associate professor of surgery at the University of Kentucky College of Medicine.*



Figure 1. Anterior displacement of stomach by swollen pancreas and edematous peri-pancreatic tissues.

signs of peritoneal irritation, in the vast majority of cases one does not find the board-like abdominal rigidity typical of acute peritonitis due to perforation of a hollow viscus. Epigastric and left upper quadrant tenderness are usually present. Bowel sounds are hypoactive or absent. There is always some degree of paralytic ileus.

In very severe cases, evidence of retroperitoneal hemorrhage may be found in the form of a bluish discoloration or bruising in the left flank within 12 to 24 hours after the onset of the attack. This is known as Gray-Turner's sign. About 25% of the patients have clinical jaundice.

In the early phase of the illness the temperature is, as a rule, only moderately elevated. The pulse is frequently rapid and the rapid pulse along with a falling blood pressure is a harbinger of the redoubtable shock which to varying degrees is present in the majority of cases.

Radiology

There are no direct radiological signs of acute pancreatitis. There are, however, several indirect radiological findings which point to this diagnosis. A flat plate of the abdomen may reveal a dilated loop of proximal small bowel representing paralytic ileus localized to a loop of small intestine adjacent to the inflamed pancreas (sentinel ileus). An upper G.I. series taken within the first 24 to 48 hours after the onset of acute pancreatitis may show anterior displacement of the stomach by the edematous pancreas and peripancreatic tissues (Figure 1). A very valuable diagnostic clue to the existence of acute pancreatitis is the finding of either a left sided pleural effusion, or an area of discoid atelectasis in one of the lower lobes. This pathology usually appears within 24 to 48 hours following the onset of the attack. These findings in a patient with an acute abdominal condition strongly suggest acute pancreatitis.

Laboratory Findings

(a) *Serum Amylase:* Serum amylase is elevated in approximately 60-70% of cases. This remains the most useful diagnostic test and should be performed routinely in all patients with an acute abdomen, particularly with a history of alcoholism. In general the serum amylase remains elevated for 24 to 72 hours and then gradually returns to normal. Sustained high levels indicate continuing severe disease. With extremely severe pancreatitis accompanied by widespread pancreatic necrosis, enzyme levels may be only moderately elevated. It is important to remember that there are several causes other than acute pancreatitis for a high serum amylase:

—perforated duodenal ulcer.

—small bowel obstruction with strangulated intestine.

—mesenteric vascular occlusion.

—acute cholecystitis.

—mumps.

Since the management of acute pancreatitis is generally conservative, it is obvious that non-intervention on the basis of the serum amylase alone would have catastrophic results in these other conditions except for mumps, of course.

In a healthy individual the administration of analgesic agents such as morphine and codeine may increase the serum amylase. The clinician should be aware of this before evaluating the laboratory data.

When pleural effusion is associated with acute pancreatitis, the pleural fluid contains very high amylase levels. Fluid withdrawn from the peritoneal cavity of a patient with acute pancreatitis by a peritoneal tap contains a high amylase level. This can also lead to diagnostic errors since the same will be true for peritoneal fluid in all the conditions listed above except cholecystitis. The only point that may be of some help is that a smear of peritoneal fluid in cases of strangulated intestine usually shows massive bacterial contamination not seen early

in the course of acute pancreatitis or perforated duodenal ulcer.

(b) *Serum Lipase*: Serum lipase values may be of help to the clinician since they remain elevated for longer periods of time after the acute attack. However, the test is not as easily accomplished as determination of serum amylase and therefore is not carried out frequently.

(c) *Blood Sugar:* Hyperglycemia is present in approximately 10% of cases of acute pancreatitis particularly of the severe variety and is due to damage of the islets of Langerhans by the diffuse pancreatic inflammatory process.

(d) *Serum Bilirubin:* Jaundice is found in approximately 25% of cases of acute pancreatitis and results from obstruction of the common bile duct by the same stone responsible for the acute pancreatitis or from an actual hepatitis caused by the high blood levels of pancreatic proteases or from involvement of the distal segment of the common bile duct in the pancreatic inflammation.

(e) *Serum Calcium:* Frequently the serum calcium falls, sometimes to levels low enough to cause tetany. Combination of ionized calcium with fatty acids liberated or hydrolysis of neutral fat causes the hypocalcemia. The degree of lowering of serum calcium is an index of the amount of fat necrosis taking place and in turn of the severity of the disease. A serum calcium low enough to cause tetany is usually a sign of grave prognostic significance.

(f) *Serum Magnesium:* Only recently has it been recognized that a fall in serum magnesium may also occur during an attack of acute pancreatitis.[4] In our experience, this is more frequent in alcoholics.

(g) *Serum Triglycerides:* Occasionally the clinician may encounter frankly hyperlipemic serum upon withdrawing blood from a patient with acute pancreatitis. The relationship of hyperlipemia to pancreatitis is an interesting one. Familial hyperlipemia, a relatively rare condition, is frequently accompanied by acute pancreatitis particularly of the chronic relapsing variety.[5] On the other hand, acute pancreatitis, for unknown reasons, is sometimes associated with transitory hyperlipemia that recedes as the attack subsides. It is interesting that hyperlipemia occasionally accompanies experimental pancreatitis in dogs.

Management

The therapeutic goals in the management of acute pancreatitis are as follows:

1. *Treatment of Shock:* The corner stone of the management of acute pancreatitis lies in the prompt recognition and treatment of shock which to varying degrees is almost always present. Hypovolemic shock is the usual cause of death during the early course of the illness. The degree of shock may not be recognized because of the intense hemoconcentration resulting in high hematocrit and hemoglobin levels despite large blood and plasma volume deficits. Often the hypotension is out of proportion to the fall in blood volume and this has led to the recognition that toxic vaso-action substances such as bradykinin probably play a contributory role. Regardless of the nature of the responsible factors, treatment remains the same: vigorous blood transfusion in amounts necessary to restore the blood pressure to normal levels. When the hemoconcentration is severe, we administer serum albumin as a 25% solution in amounts of 200 to 300 ml. daily. Non colloid intravenous fluids should be given concomitantly to maintain nomal urinary output. Needless to say, in a seriously ill patient the latter can be monitored only by means of an indwelling urinary catheter. Related to the shock or to other unrecognized factors, acute renal failure is another frequent cause of early death in acute pancreatitis. When the serum calcium is low, calcium should be administered as a 10% solution of calcium gluconate in amounts of 10 to 20 ml. per day intravenously. Vasopressors should be used only as a last resort.

2. *Relief of pain:* As previously mentioned the pain experienced by patients with acute pancreatitis may be excruciating and demands prompt relief. Unfortunately, all analgesic agents, including meperidine, have a spasmogenic effect on the sphincter of Oddi and are theoretically capable of aggravating the underlying pathology. Therefore their use, particularly in large amounts, is contraindicated. When the pain experienced by the patient is severe enough to necessitate large amounts of narcotics for its relief, a splanchnic block should be performed immediately. When the pain is only of a mild degree small doses of meperidine accompanied by atropine (or a similar anticholinergic) can be used safely.

3. *Temporary inhibition of pancreatic secretion:* Practically all of the manifestations of

pancreatitis result from digestion of the gland and surrounding tissues and often of tissues at distant sites by pancreatic enzymes particularly those with proteolytic activity. Therefore, one of the therapeutic goals is to place the pancreas at rest. This is achieved both by naso-gastric suction and by anticholinergic agents. Naso-gastric suction, by preventing gastric acid secretions from reaching the duodenum diminishes the amount of secretin elaborated by the mucosa of the duodenum and in turn prevents pancreatic stimulation via that route. Anticholinergic agents tend to depress pancreatic secretion of enzymes.

4. *Prevention of infection:* As will be discussed below, infection supervening in the necrotic peripancreatic tissues is one of the most redoubtable conditions the surgeon can be called upon to treat. In so far as possible one should take whatever measures are available to prevent this. In our opinion acute pancreatitis is one of the few conditions in which the preventive administration of antibiotics should be a matter of routine. How effective this approach is in preventing pancreatic abscess and peripancreatic abscess is of course only a matter of conjecture.

The conservative treatment of acute pancreatitis, as outlined in the preceding paragraph, has been responsible over the past 10 years for a gradual decrease in the early mortality from approximately 25% to approximately 5 to 10%. Undoubtedly, a conservative approach is far better than systematic surgical intervention. However, differentiation between acute pancreatitis and some other acute abdominal condition for which surgical exploration is mandatory is often not possible. Whenever there is the slightest doubt the clinician should always lean in the direction of exploratory laparotomy because the consequences of nonintervention in a case of perforated duodenal ulcer or strangulated small bowel are disastrous whereas a simple coeliotomy in face of acute pancreatitis is usually of little consequence as long as the surgeon refrains from injudicious intraperitoneal manipulations. When biliary tract disease is found it should be treated by the most expeditious approach, i.e., cholecystostomy in preference to cholecystectomy. Such procedures as sphincterotomy have, in our opinion, absolutely no place in the management of acute pancreatitis. The peritoneal cavity should be thoroughly lavaged with liberal amounts of normal saline solution prior to closure. The pancreas should not be drained for fear of infecting the area or creating an external pancreatic fistula.



Figure 2. Characteristic abdominal deformity in a patient with a large pancreatic pseudocyst.

Prior to the advent of the modern conservative management of acute pancreatitis the majority of deaths occurred during the first week of the illness. At the present time the majority of deaths that do occur are delayed and are caused by complications of acute pancreatitis some of which are discussed below.

Pancreatic Pseudocyst

Almost always, pancreatic pseudocyst complicates acute pancreatitis either of spontaneous or traumatic origin; occasionally it occurs as a complication of pancreatic ductal obstruction by an adenocarcinoma of the head of the pancreas. A pseudocyst is formed by exudate which, during the initial phases of the attack of pancreatitis, seeps out of the gland along retroperitoneal tissue planes. When this extravasation of fluid is massive, loculation takes place in one of several areas: above the stomach, behind the gastrohepatic ligament, be-

tween the leaves of the transverse mesocolon or within the leaves of the mesentery of the small bowel. However, by far the most frequent site of fluid accumulation is the lesser peritoneal cavity where the fluid becomes sequestered by the posterior wall of the stomach, the gastrocolic ligament and the transverse mesocolon. Thus a fluid filled pocket lined by granulation tissue is formed. Not being a tumor, a pancreatic pseudocyst cannot be excised. Occasionally the overly temeritous surgeon may attempt to do so to his eventual chagrin.

The recognition of a pancreatic pseudocyst is usually simple and is based upon the finding of an epigastric mass (Figure 2) developing rapidly in a patient having recently had an attack of acute pancreatitis. The mass is almost always palpable, is sometimes fluctuant and, an important characteristic, does not move with respiration. Another diagnostic feature of pseudocysts is their amazing tendency to wide and rapid changes in size. We have seen secondary shock appear in patients because of rapid accumulation of fluid in the cyst.

Radiology may help in the diagnosis of small cysts by showing displacement of the surrounding viscera. A pseudocyst in its usual location displaces the stomach anteriorly and the transverse colon inferiorly. Occasionally, a false positive diagnosis of pseudocyst results from attributing displacement of the stomach by an enlarged left lobe of the liver to a pseudocyst. This problem may occur in alcoholics who of course, are liable both to pancreatitis and cirrhosis of the liver.

Potentially, a patient harbouring a pseudocyst is exposed to the serious complication of an internal fistula developing into the G.I. tract. The proteolytic enzymes in the pseudocyst frequently erode the cyst wall. Perforation can take place into the free peritoneal cavity with resulting peritonitis or more frequently as a fistula between the cyst and one of the surrounding viscera: stomach, duodenum or transverse colon (Figure 3). Severe, sometimes fulminating hemorrhage usually accompanies erosion of the bowel wall. The occurrence of G.I. hemorrhage, upper or lower, in a patient known to have a pancreatic pseudocyst signifies erosion of the cyst into the gastrointestinal tract.

The reason pancreatic pseudocysts do not regress spontaneously is a frequently raised question. Although this happens occasionally,



Figure 3. Pancreatic pseudocyst treated by external drainage. A fistula has formed between the cyst cavity and the stomach. Dye injected into the cyst enters the stomach.

in the majority of instances these lesions expand. This chronicity is due to the existence of a communication between the cyst and the pancreatic ductal system via which pancreatic juice continues to enter the cyst. The amount of juice entering the cyst and conversely any spontaneous decompression of the cyst via this communication depends upon the degree of pancreatic ductal obstruction. The latter may vary and this explains why the size of pancreatic pseudocysts often fluctuates tremendously. This connection between the cyst and the pancreatic ducts is responsible for the immediate pancreatic fistula usually complicating an ill-advised external drainage of a pseudocyst. In addition, a pancreatic pseudocyst, similarly to a hematoma tends to expand because as the blood in the cyst is digested by proteolytic enzymes the osmolarity of the cyst fluid increases leading to a shift of extracellular fluid into the cyst.

Management: Management of a recognized pseudocyst is always surgical. For reasons just mentioned, older techniques such as marsupialization or external drainage should be abandoned in preference for some types of internal drainage. Because of the communication between the pancreatic ducts and the cyst, it would seem theoretically feasible to decompress a cyst via the pancreatic duct by means of a sphincterotomy. Unfortunately the size of the communication between the cyst and the pancreatic ductal system is so small and variable that decompression of the cyst via the pancreatic ducts is not practical except under cer-

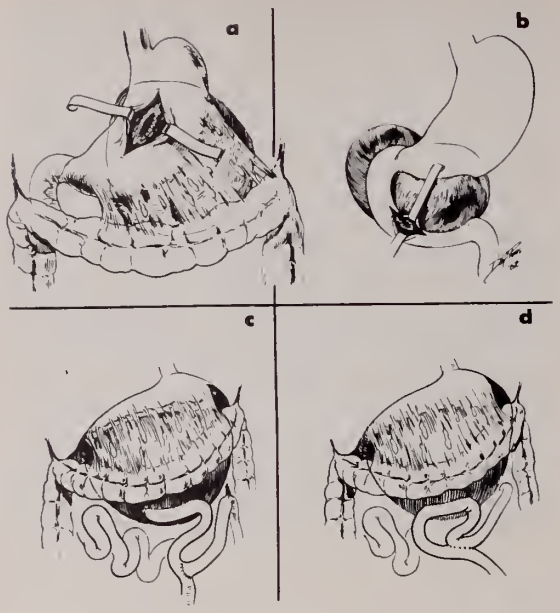


Figure 4. Various methods by which internal drainage of pancreatic pseudocyst may be performed.

tain selected conditions. The preferred method of treatment is to drain the cyst into the gastrointestinal tract by making an anastomosis either between the cyst and the stomach, the cyst and the duodenum, or between the cyst and a loop of jejunum (Figure 4). We prefer the latter technique. This approach to the management of pancreatic pseudocyst offers virtual certainty of cure with minimal mortality and morbidity.

Peripancreatic Abscess

Occasionally the necrotic peripancreatic tissue becomes infected and a peripancreatic abscess develops. This is a particularly grave complication because the abscess instead of becoming walled off as abscesses of other origins usually do, tends to spread along retroperitoneal planes opened up by the pancreatic exudate. Thus, these abscesses often dissect widely around the pancreas. The signs of a peripancreatic abscess are spiking fever and a high white count occurring within one or two weeks after an attack of acute pancreatitis. The gravity of this complication may be compounded by severe hemorrhage due to digestion by pancreatic trypsin of large vessels involved in the abscess.[6] When the patient has had a previous surgical exploration, this complication is announced by profuse bleeding along drain sites.

Small, well localized abscesses usually respond to simple drainage. The diffuse lesions extending widely in the retroperitoneal space around the pancreas are extremely difficult to treat since this space does not lend itself well to external drainage. Anterior drainage by means of sump drains or Penrose drains is inefficient because of the posterior location of the collection and because the latter usually contains clumps of partially digested fat and blood clot. We have found that the only successful way to drain peripancreatic abscesses is via a large left flank incision opening directly into the retroperitoneal space. The incision is left partially open to permit daily lavage of the abscess cavity.

Chronic Pancreatitis

Traditionally, all cases of acute pancreatitis have been lumped together. In such series one finds that the majority of the patients either have gall stones or are chronic alcoholics. More and more it is realized that pancreatitis associated with gall stones must be completely separated from the pancreatic changes seen in chronic alcoholics.

The diagnosis of chronic relapsing pancreatitis is based upon the repeated occurrence of attacks of epigastric pain which may vary in degree all the way from minor attacks of "indigestion" to extremely severe pain requiring hospital admission. Serum amylase levels measured during such an attack, are usually elevated. In other words each attack of this chronic condition simulates a small attack of acute pancreatitis. Characteristically, after many such attacks, each subsequent episode decreases in severity as the pancreas becomes replaced by inflammatory scar tissue. The acute episodes of pain are replaced by almost continuous dull



Figure 5. Long cicatricial stricture of the common bile duct in a patient with chronic pancreatitis.

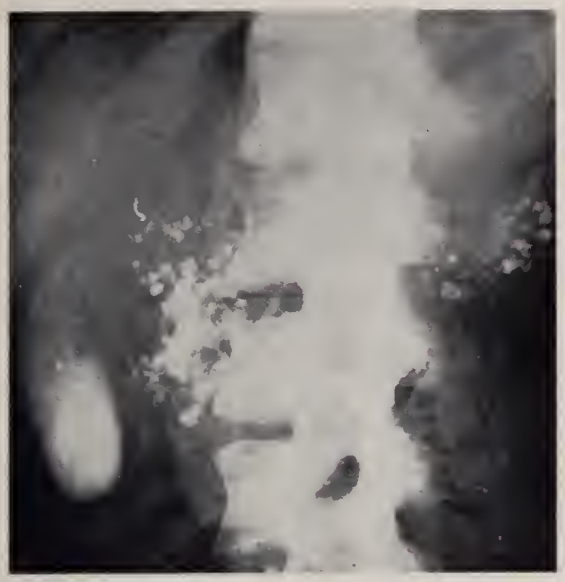


Figure 6. Characteristic pancreatic calcification in a patient with chronic pancreatitis. With rare exceptions, this picture is associated with chronic alcoholism.

epigastric pain. The destroyed pancreas gradually loses its exocrine function and a syndrome of malabsorbtion and weight loss supervenes. In the final stages of the illness, involvement of the islets of Langerhans by the chronic inflammatory process is responsible for diabetes. Frequently the chronic cicatricial process in the pancreas involves the common bile duct as it runs through the head of the gland and causes a stricture of the duct and obstructive jaundice. (Figure 5)

Typical cases of far advanced pancreatitis are easily recognizable particularly if pancreatic calcification is present (Figure 6). Early in the course of the illness, diagnosis may be more difficult especially if one is not able to measure the serum amylase during an acute attack. The only way to make the diagnosis under these conditions is to carry out a secretin test and demonstrate a decreased rate of secretion of pancreatic juice along with a decreased concentration of bicarbonate ion in the juice. If the patient has associated chronic cholelithiasis or chronic alcoholism, the suspicion of chronic pancreatitis is always much higher. When chronic pancreatitis has disease of the biliary tract as its etiology, the course is far more benign. Attacks are not as frequent and as severe and, of great importance to the clinician, the condition is far more amenable to treatment. Much of the controversy that has centered around the treatment of chronic pancreatitis is due to the above mentioned fact that the varying nature of the disease according to its etiology has not been recognized. For instance, the results of sphincterotomy performed on series of cases of chronic pancreatitis have not been evaluated with respect to the biliary or alcoholic origin of the pancreatitis. It has become quite apparent to us that when chronic pancreatitis is associated with biliary tract disease—usually chronic cholelithiasis—cholecystectomy and if necessary choledochotomy is sufficient to provide a lasting cure. In such cases we no longer carry out sphincterotomy unless the operative cholangiogram shows very clear evidence of a stricture at the level of the sphinter of Oddi.

The problem of management is entirely different when dealing with chronic relapsing pancreatitis in alcoholics. In these cases the disease is far more severe and its course far more relentless. The picture of calcified pancreas with severe exocrine deficiency resulting in a pronounced weight loss and diabetes is almost always associated with chronic alcoholism. Usually one is unable to find biliary tract disease in these patients except for acquired benign stricture of the distal segment of the bile duct resulting from the pancreatitis as described earlier. As one would expect, empirical cholecystectomy and sphincterotomy in the absence of any disease of the biliary tract has been most disappointing. Many other procedures have been utilized to treat this most difficult condition: vagotomy, subtotal gastric resection, sympathectomy, coeliac ganglionectomy, distal pancreatectomy, pancreato-duodenectomy. During the last decade, however, the most popular procedure has been retrograde decompression of the pancreatic duct. The rationale for this procedure lies in the multiple areas of stenosis of the pancreatic duct with dilatation of the duct in the tail of the gland which can be demonstrated by operative pancreatogram. Since these areas of stricture formation are proximal to the sphincter, a sphincterotomy could not be expected to relieve the obstructive process. Decompression of the pancreatic ductal system at the tail of the gland by means of a Roux-en-Y loop is a more logical procedure.[8] The success obtained with this operation performed in various centers around the country has been fair. In our experience patients have experienced immediate symptomatic relief of pain. Unfortunately, the long term results have been

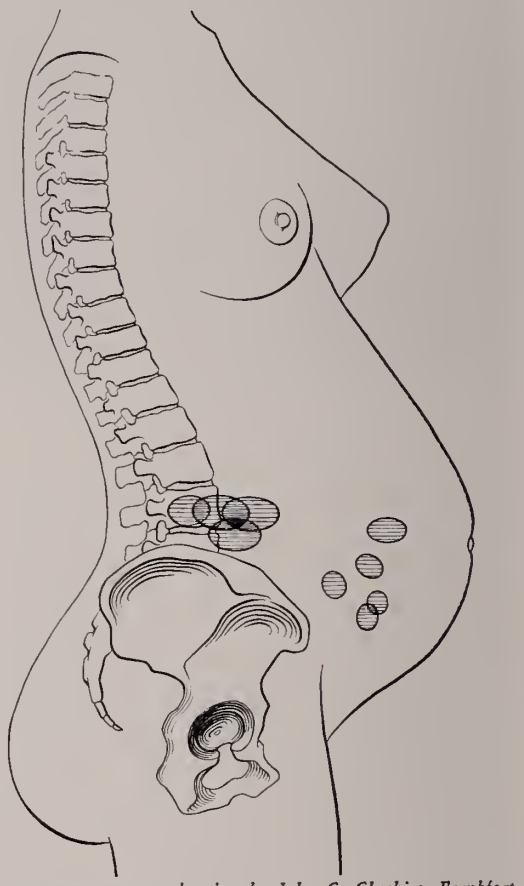
Continued on Page 1035

Appendicitis in Pregnancy

THOMAS H. BAKER, M.D.
Frankfort, Ky.

Appendicitis after the first trimester may be quite difficult to diagnose, as the classical signs are often absent. The pain and tenderness may mimic pyelitis of pregnancy perfectly.

ABOUT once every thousand deliveries an appendectomy is performed on a pregnant woman. Approximately half of these cases prove to have an acutely inflamed appendix.[5, 6, 7, 9] In private practice the opportunity to observe a number of true appendicitis cases during gestation is necessarily limited by the volume required to accumulate experience in the diagnosis. Since 80% of the cases reported in large series are seen during the first six months of gestation[9] little has been recorded about the more advanced pregnancy. During the first twelve weeks appendicitis is quite like that seen in the non-pregnant woman and will not be discussed except to say that it is most commonly confused with acute salpingitis and ectopic pregnancy.[6] Recently a tenth case of acute appendicitis in pregnancy has been made available to me for examination and comparison with the others seen during the past four years. The stage of gestation ranges from 14 to 34 weeks, most falling between 19 to 32 weeks. A few facts are worth presenting from this small series.



drawing by John C. Cheshire, Frankfort

Figure 1. Areas of Maximum Tenderness in Ten Cases of Acute Appendicitis During Pregnancy.

Diagnosis

Physical examination was deceptively innocent in some cases despite rather advanced degrees of inflammation. No patient showed a temperature elevation on admission to the hospital greater than 99.8 degrees except for one young girl with an appendix ruptured after 72 hours of abdominal pain. She had been treated by her doctor for gastroenteritis with paregoric and had failed to return for re-examination the following morning. In all these cases the abdomen was perfectly soft with no suggestion of muscle spasm. The ruptured appendix case mentioned above had full-blown peritonitis and her abdomen could be palpated with no muscular resistance. Another striking finding was the absolute lack of rebound pain on release of the abdominal wall in over half of the patients. The surgeon must orient his thinking to these facts after having been conditioned to rely on them. The white blood count was frequently of no value. Several severe cases had a normal white count, while others which were mild had elevated counts. The physiologic elevation of the white blood count during pregnancy is confusing as well.

Pain and tenderness were always present somewhere on the right side.[7] This tended to be higher as the pregnancy advanced, but not always. One late case with a low-lying long appendix experienced pain in the right inguinal

area, while one early case with a retrocaecal appendix complained of pain in the kidney area. In general, however, tenderness was much more diffuse and posterior than is usually stated, tending to be located higher and posterio-lateral as the pregnancy progressed. (see illustration)

It is commonly taught that abruptio, torsion of an adnexal mass, uterine infection, and ureteral stone are the conditions which are usually simulated by appendicitis in pregnancy.[6] On the contrary, most of these cases were thought to be pyelonephritis when first seen, and this was the disease most difficult to rule out.[3, 14] It is not too unusual to have an acutely infected, poorly draining kidney which does not lend itself to early diagnosis on urinalysis. Many cases were seen just at the time that the uterus is thought to exert its greatest effect in blocking ureteral peristalsis. The diffuse right flank pain is quite deceptive and may mimic kidney infection perfectly. A strong point against this condition was the lack of spiking fever and chills associated with a greatly elevated white count which should have been present if an acutely inflamed and blocked kidney were the cause of the pain. In one case the deception was so exact that an intravenous pyelogram (shielding the pregnancy and taking one film) was taken, demonstrating excellent drainage and prompting laparotomy.

During the last half of pregnancy pelvic and rectal examinations were normal. A far advanced case of peritonitis had no tenderness on deep rectal palpation. A very significant and always present finding was a definite increase in pain when lying on the right side, relieved when lying on the left side. This is in contrast to "round ligament pain" which is the reverse. Most patients complained bitterly when asked to turn on the right side. A history of high epigastric pain with secondary nausea which "changed" and shifted to somewhere in the right half of the abdomen, flank or back was especially reliable and could almost always be obtained with careful questioning. After about twelve hours the pain may be quite diffuse and at times is experienced as a dull ache throughout the entire right flank extending down the right anterior and medial thigh. The poor localization of pain coupled with few signs of peritoneal irritation make the early symptoms especially important in accurate diagnosis. In many cases physical examination was almost worthless and the history was the only reliable evidence that an inflamed appendix was hidden beneath the gravid uterus.

Treatment

It is natural to be hesitant in operating on the pregnant woman when the usual localizing signs are not present. Conditioned to finding certain physical signs and usually slightly insecure in his dealings with the gravid uterus, the surgeon may be reluctant to open the peritoneal cavity for fear of interrupting pregnancy after

Table I.

Patients With Acute Appendicitis During Pregnancy

Case	Age	Weeks	WBC	Temp. (Adm.)	Spasm	Rebound	Tenderness	Incision	Result
No. 1	23	14	15,000	99.0	0	3+	McBurney's pt.	McBurney	5# infant, surv.
No. 2	17	19	25,400	99.6	0	3+	McBurney's pt.	McBurney	term delivery
No. 3	16	22	10,000	98.6	0	0	1" superio-medial ant. sup. il. spine	R. paramedian	pre-eclampsia near term
No. 4	24	26	7,800	99.0	0	3+	level of umbilicus R. flank & CVA	R. paramedian	6# infant, surv.
No. 5	23	30	11,350	99.8	0	0	above crest, R. flank	long McBur.	term delivery
No. 6	18	32	13,600	98.2	0	3+	level umbilicus, 6cms to right	R. paramedian	term delivery
No. 7	32	32	12,850	99.6	0	0	level of crest, R. flank & CVA	R. paramedian	unknown; moved
No. 8	24	29	13,000	99.2	0	0	level of crest, R. flank & CVA	high TV split	unknown
No. 9	30	24	8,500	99.8	0	2+	R. flank & CVA, level of umbilicus	R. paramedian	placenta prev. infant died
No. 10	19	34	14,500	103.0	0	0	2" above McBurney's area	oblique	delivered 24 hrs infant surv.

removal of a normal appendix. A careful appendectomy in itself has little effect on pregnancy.[7] Acute appendicitis, on the other hand, causes significant fetal and maternal loss if not treated promptly.[8] Hesitancy and reluctance must be overcome. Localizing signs may never occur. Peritonitis is extremely serious in the gravid patient since the usual protective mechanisms are hampered by the physical presence of the pregnancy. If the inflammatory process is advanced, especially if the uterine wall itself is irritated from intimate contact with the appendix, all the progesterone in the hospital pharmacy will not prevent premature labor.[3, 7, 11] It seems that some form of progesterone is always given to these patients, but very doubtful if any beneficial effect is produced in the uterus. The doctor usually feels better after prescribing it, if not the patient.

If the fetus is viable, sedation should be with narcotics in minimal amounts. Should labor ensue, there is little danger of wound disruption,[3] but to play safe, forceps should be applied as soon as practical to avoid pushing efforts. Regional anesthesia is preferred for the same reason, and narcotic antagonists to give the premature infant every chance. Uterine manipulation should of course be avoided. If cesarean section is necessary on obstetrical grounds, in the face of peritonitis, hysterectomy may be lifesaving.

References

1. Babler, E. A.: *Appendicitis in Pregnancy,* J.A.M.A., 51: 1310, 1908.
2. Baer, J. L., Reis, R. A., & Arens, R. A.: *Appendicitis in Pregnancy, with Changes in Position and Axis of Normal Appendix in Pregnancy,* J.A.M.A., 98:1359, 1932.
3. Bassett, J. W.: *Appendicitis in Pregnancy,* Am. J. Obst. & Gynec., 82:828, 1961.
4. Black, W. P.: *Appendicitis in Pregnancy,* Brit. M. J., 1:1938, 1960.
5. Bronstein, E. S. & Friedman, M.: *Acute Appendicitis in Pregnancy,* Am. J. Obst. & Gynec., 86:514, 1963.
6. Eastman, N. J. & Hellman, L. M.: Williams Obstetrics, ed. 12, New York, 1961, Appleton-Century-Crofts, Inc., p. 808.
7. Guttmacher, A. F. & Rovinsky, J. J. Ed.: Medical, Surgical and Gynecological Complications of Pregnancy, Baltimore, 1960, Williams & Wilkins Co., p. 233.
8. Hoffman, E. S. & Suzuki, M.: *Acute Appendicitis in Pregnancy,* West. J. Surg., 57:150, 1949.
9. Hoffman, E. S. & Suzuki, M.: *Acute Appendicitis in Pregnancy;* Ten Year Survey, Am. J. Obst. & Gynec., 67:1338, 1954.
10. MacArthur, L. L.: *Gestation Complicated by Appendiceal Abscess,* Am. J. Obst., 31:181, 228, 1895.
11. McDonald, A. L.: *Appendicitis in Pregnancy,* Am. J. Obst. & Gynec., 18:110, 1929.
12. Parker, R. B.: *Acute Appendicitis in Late Pregnancy,* Lancet, 1:1252, 1954.
13. Priddle, H. D. & Hesseltine, H. C.: *Acute Appendicitis in the Obstetric Patient,* Am. J. Obst. & Gynec., 62:150, 1951.
14. Kretchmar, L. H. & McDonald, D. F.: *The Urine Sediment in Acute Appendicitis,* Arch. Surg., 87:209, 1963.
15. Sarason, E. L. & Bauman, S.: *Acute Appendicitis in Pregnancy: Difficulties in Diagnosis,* Obst. & Gynec., 22:382, 1963.

Remember

The 1965 KMA Interim Meeting

March 18

Gabe's Restaurant, Owensboro

The Role and Contributions of the Psychiatrist in Private Practice†

Hollis Johnson, M.D.*
Louisville, Ky.

Since World War II the practice of psychiatry has moved from the large state mental hospital to the community with the psychiatrist in private practice as are the majority of physicians. A historical review of the mental health movement is presented.

MEDICINE and its institutions have traditionally accepted responsibility for the diagnosis and treatment of disease. At the same time, community participation has come through the public health movement and its institutions for the control of communicable disease. If the diagnosis and treatment of emotional and mental illness are the responsibility of the medical profession and its institutions, the preservation and enhancement of the mental well-being of its members is the obligation of society and the community. There is no clear-cut borderline between these functions, but it is becoming increasingly evident that the promotion and support of mental health are a community responsibility.

Traditionally, psychiatry has concerned itself with the diagnosis and treatment of mental disorders. It is only since the second decade of this century that psychiatry has begun to concern itself with community mental health, this largely through mental health or hygiene organizations.

History

The earliest mental health movement concerned itself first of all with housing for the mentally ill and secondly with humane care. The significance of Phillipe Pinel of Paris and the Tuke family of York, England, can never be over-estimated in both these regards. The prestige of Pinel caused psychiatrists to give serious attention to his methods, while the approach to the care of the mentally ill employed by Samuel and D. Hack Tuke at the Retreat in York, England, had much impact on the Quakers and their spread of these attitudes to America. Another early influence in the care of the mentally ill stems from the significance to the colonial medical profession of Benjamin Rush, who from 1783 devoted a considerable part of his time and interest to the problems of mental illness. His association with the Pennsylvania Hospital had much to do with the fact that in 1841 it was the first general hospital in this country to erect a wing for the care of the mentally ill.

As for social attitudes regarding mental illness, the first half of the 19th century in this country was characterized by the association of mental illness with pauperism, resulting in a hapless deterioration in the concept of care for mental illness, as well as in attitudes toward those suffering from it. Poor houses became, in great part, also mental hospitals, with consequent abuses of the persons and property of the mentally ill. These conditions set the stage for Dorothea Lynde Dix who conducted a crusade unparralled in history on behalf of the mentally ill. As a direct result of her efforts, mental illness had begun to free itself from the problems of pauperism during the latter half of the 19th century. The effects of this association were still to be felt in the public attitude, however, well into the 20th century.

Also in the latter part of the 19th century, there began to appear a general recognition of the need for special hospitals in the larger cities for the treatment of acutely mentally ill persons. Since these persons usually were handled by the police as "drunk cases," medical attention for them was extremely difficult to obtain. Massachusetts showed the way in the establishment of the Boston Psychopathic Hospital which opened in 1912 with Dr. E. E. Southard as its director. Another name important in this

†*Presented before the Kentucky Psychiatric Association September 25, 1963, during the 1963 KMA Annual Meeting at Lexington.*
**Associate clinical professor of psychiatry at the University of Louisville School of Medicine.*

milestone of community care of the mentally ill was that of the psychiatrist, Dr. L. Vernon Briggs. Although he had energetically campaigned for hospitals located in metropolitan centers for "first care" of the mentally ill, his name is more permanently attached to another accomplishment. This is the "Briggs Law" enacted in 1921 in Massachusetts which is both a model of the type of law used to better define criminal responsibility and is also a monumental example of the responsibility of the psychiatrist to his community.

The first decade of the 20th century witnessed a remarkable social phenomenon; that is, the wide-spread participation of citizens in the improvement of a variety of medical care programs. Appearing on the scene were numerous voluntary health organizations, among them the predecessors of many present day national voluntary health societies. It was in 1909 that the National Committee for Mental Hygiene, one of the parent bodies of the National Association for Mental Health, was born.

Changing Relations

Prior to World War II, psychiatry was practiced largely in state institutions and in private, profit and non-profit, institutions in the population centers of the country. During and following World War II, psychiatry attained added impetus through social pressure and community awareness. The sharp increase in the number of private practicing psychiatrists that followed has been a reflection and a part of this phenomenon. This movement of the practice of psychiatry from the institution into a close integral association with the community where the psychiatrist practices, as does any other physician, has brought him into a closer relationship to the problems of community mental health.

The example of leadership of the pioneers of the private practice of psychiatry in this area provides a pattern and ideal for us all. In Louisville, psychiatric units in three general hospitals have been established, a large non-profit psychiatric hospital has become an integral part of the community, and active participation on the volunteer faculty of the community medical school has been maintained. Also, through the joint efforts of the full-time psychiatric faculty of the medical school, the private practicing psychiatrists of the community, the State Department of Mental Health, and the Norton Memorial Infirmary, a psychiatric clinic for adults has been established.

In addition to this, psychiatrists are serving on the faculties of two theological seminaries; a school of social work; as active consultants to the juvenile court, as well as board members of the juvenile court; and consultants to children's agencies, as well as state agencies.

These are only a few of the examples of the extent of participation in community activity by our Louisville group, and I am sure similar examples can be given for the group in Lexington. I review these activities not only because of pride in my colleagues, but also to point out that one's influence goes not only through his professional contact but also through his active participation in the needs of special groups in his community.

Above all, the psychiatrist's role in community mental health is to practice the best quality of psychiatry. The scope of his influence is not quite known to him and many attitudes and opinions are generated as a result of his efforts, not only through his patients and their families, but also through referring physicians and agencies. Perhaps all too often we leave a referring physician in the dark as to what is going on and as to what contribution he can make to the patient's welfare. At the same time, I am occasionally frightened to see the finality with which a psychiatric consultation report is regarded by some referring physicians and social agencies.

Summation

The private practicing psychiatrist's role in community mental health is twofold. First, to provide diagnostic and treatment services for mental disorders within the medical community; and second, but not least, to assume a role of leadership in community problems and services where his special training and experience is of positive value. Not only psychiatrists, but also all practitioners of medicine, need to assume a role of leadership in helping their communities to work out problems of mental health and mental illness. The trend has started nation-wide. People are aware of the need and are going to do something about it. Let's make ourselves available through county and state medical societies to lend assistance to this—one of today's most pressing health problems.

Sudden, Unexpected Death in Infancy Pathology, Pathogenesis, and Possibility of Prevention†

Daniel Stowens, M.D.,* Edward Callahan, M.D.,** and Jennifer Clay, M.D.***

Louisville, Ky.

The anatomy, epidemiology and chemistry of infants who were "crib deaths" are described. Similarities between these anatomic lesions and those of anaphylactic origin are demonstrated. An hypothesis on pathogenesis and prevention is advanced.

THE term "Sudden, Unexpected Death" in infancy refers to deaths occurring in children who have ostensibly been asymptomatic and healthy. Such deaths have also been referred to as "crib deaths" "suffocation," etc. The problem is one of major medical importance because it claims the lives of about 20,000 infants a year. Exact information as to its frequency is virtually impossible to obtain, however, because "sudden, unexpected death" is not a legally permissible death certificate entry and, therefore, other disease processes are assigned as the cause of death. Perhaps a better idea of frequency can be obtained from the statistics for Jefferson County, Kentucky, where one of us (DS) is a Deputy Coroner and himself performs the postmortem examinations on infants and assigns the cause of death. In the county, which has a population of roughly 600,000, there were approximately 100 deaths of this nature in 1962. Personal communications from the Medical Examiners of Broward County, Florida and Los Angeles County, California, indicate that the incidence in those areas is of the same order.

The "disease" is one which has its peak incidence at three months of age; it is twice as common in boys as it is in girls, and in some areas there is a slightly increased incidence during the winter months.[1,2] Instances of more than one such death in the same family have been reported.[3]

Previous studies of the nature and causes of "Sudden Death" have been valuable only insofar as they have contributed negative data. No specific bacterial or viral agent has been recovered.[4] There are no gross anatomic malformations, although an occasional infant with small adrenals has been described,[5] and no abnormalities of blood chemistries have been found. Although the question of deficient immunity has been raised these infants have normal levels of gamma globulins, or even higher than normal levels.[6]

Current Studies

The present studies are based on work done at Children's Hospital of Louisville. During 1962-1963, 44 patients were referred to the pathology department by the Coroner's Office, Jefferson County, for postmortem examination. Included in the studies were only those infants who had no previous history of disease (by which is meant as far as could be determined there were no symptoms even of a minor nature) and concerning whom there was no indication of neglect or foul play as determined by the Coroner's investigation.

The basic observations were of an anatomic

†*Presented at the September 24, 1963 meeting of the Kentucky Society of Pathologists during the KSMA Annual Meeting at Lexington.*

**Associate clinical professor of pathology and associate in pediatrics at the University of Louisville School of Medicine.*

***Fellow in pathology, Memorial Hospital, New York, N.Y. At time of writing, resident in pathology, Louisville General Hospital.*

****Intern, Louisville General Hospital. At time of writing, Senior medical student at the University of Louisville School of Medicine.*

nature which in turn led to various chemical studies. The presentation, therefore, will be in that order. The single gross anatomic peculiarity consistently present in all children was an enlarged thymus. In a control series the average weight of the thymus at three months of age was 12 grams, but in the infants dying suddenly and unexpectedly the average weight was 29 grams. Although the weight of the thymus is more variable than most organs, the more than two-times increase and the fact that it occurred in all of the children dying suddenly and unexpectedly is significant.

Microscopically, alterations of structure are most apparent in the lungs and kidneys. In the lungs there is generalized overexpansion of the alveolar spaces associated with considerable quantities of edema and occasionally with petechial hemorrhages, apparently of recent origin. In the kidneys the lesion primarily affects the glomerulus. (Fig. 1) The capillary tuft is enlarged and Bowman's space is either obliterated or reduced in size. The outlines of the glomerulus are indistinct and occasionally swelling of the cells of Bowman's capsule is seen. Within the tuft itself there is hypercellularity caused by swelling of what are probably mesangial cells. (It has not been possible to obtain material early enough to have the degree of preservation necessary for electron microscopic studies). Swelling of cells within the tuft is accompanied by a decrease in number and size of capillaries and although usually one or two channels can be seen the glomeruli have a bloodless look. Histochemical studies of these glomeruli indicate a loss of integrity of the basement membrane. Actual necrosis or inflammation is rare but scarred glomeruli are found in approximately half the babies, indicating trauma at some time prior to death. The tubules generally show few changes but occasionally hyaline droplet formation within the cytoplasm of the proximal tubular epithelial cells can be seen. In some infants there has been calcification of the distal tubule in the region of the macula densa. In about half of the infants there is swelling of the walls of the arterioles.

Similar, though less dramatic, changes can be seen in the liver and spleen. In the liver, swelling and pallor of the liver cells is seen while in the spleen there is prominence of the arterioles, especially of the red pulp. In the thymus no obvious lesion is seen but there is a persistence of the fetal architectural pattern.

An observation of a negative character is that there is a paucity of eosinophils in the thymus, spleen and lymph nodes, and bone marrow.

The lesions described, especially the glomerular lesions, have been present in 100 per cent of infants dying suddenly and unexpectedly. Similar alterations are occasionally found in patients dying of other causes, notably those usually associated with hypersensitivity reactions.

Postmortem studies of the urine were carried out on fifteen infants. In all there was a significant (3-4 plus) albuminuria. Chromatographic analysis of the urine revealed a diffuse aminoaciduria, though whether this is of a significant degree or not is not known, and quite significantly the presence of an abnormal compound known as a "nephrosis peptide".[7] The nature of the nephrosis peptide is not known and previously it has been found only in the urine of children suffering with classical, essential nephrosis.

Discussion

The significant features observed at postmortem examination in children dying suddenly and unexpectedly:

1. Significantly enlarged thymuses.
2. Pulmonary edema and occasional petechial hemorrhage.
3. "Reactive" glomerulitis.
4. Albuminuria.
5. Presence of an abnormal peptide in the urine.
6. A pronounced peak of incidence at three months of age.
7. A variety of less dramatic anatomic alterations such as prominence of the arterioles of the spleen, swelling of liver cells and generalized absence of eosinophils in the tissues.

In those infants studied immediately after discovering the renal lesion, studies of blood urea nitrogen, serum electrolytes, serum proteins and gamma globulins were performed. Although the BUN in approximately half of the infants was elevated (30-35 mgs%) it was not at a level consistent with a death due to renal failure. In general, gamma globulin comprised 10 per cent of the total proteins and was in the range of about 0.65 gms/ml. This is slightly higher than the control normals but not significantly so. The observations on

gamma globulins are essentially the same as those recently reported by Valdes-Dapena,[6] et al.

From the nature of the anatomic lesions it appears that the disease mechanism most likely to produce these would be a hypersensitivity reaction,[8] or, being of such a severe degree, an anaphylactic reaction. Attempts were made to demonstrate antibodies to milk, and various bacterial proteins by agar-gel diffusion techniques and in none of the babies could a reaction be seen. In seven of the babies urinary studies prior to death were available. These were obtained through the state PKU testing program. The samples returned primarily for testing for PKU are, incidentally, tested for ten other substances including urinary proteins. Five of the infants had no albumin in their urine at the time of the test for PKU. Two infants had shown measurable amounts of protein. It is likely that the albuminuria so marked at the time of death is of intermittent occurrence.

In any analysis of the pathogenesis of sudden, unexpected death in infancy, all of these factors would have to be taken into account. Previous studies indicate that an infectious basis for this syndrome is most unlikely for no consistently recoverable microorganism or viral agent has been found. Further, because of the different rates of occurrence in the sexes it is unlikely that an infectious agent was the basis for this disease. Still further, inasmuch as the infant is increasingly exposed to the general population and the possibility of infection with advancing age, it becomes difficult to reconcile the peak incidence of the disease at three months of age with an infectious hypothesis.

When the physiology of the infant at three months is analyzed in detail there is one factor of singular importance. This is the disappearance from the infant's blood stream of the antibodies received passively from the mother. It would be desirable then, inasmuch as no other single factor can be related to this particular age, to relate this factor to the syndrome. If, however, a specific infectious agent is not the cause of sudden death what role could the maternal antibodies fulfill which, upon their disappearance might prove injurious to the infant's health? Although this reasoning is somewhat teleologic it again leads to the hypothesis that sudden death may in some respect be the result of an anaphylactic reaction caused by the disappearance of passively received, protective antibodies from the mother at a time when the infant is not able to manufacture sufficient antibodies of his own to neutralize the antigens.

Having two sets of observations, the anatomic and the physiologic, which tend to lead thinking in terms of anaphylaxis and antibody-antigen reactions in general, certain other features of the disease fall in place. The striking hyperplasia of the thymus, noted since late in the 19th century,[9] especially in the light of the recent advances made in relating the thymus to the instigation of immune processes in the body can be explained on the basis of the fact that these infants have excessive loads of antigen and require larger amounts of antibodies than other infants and the entire immunologic mechanism responds, the thymus specifically, in an anatomic sense of compensatory hyperplasia. The rather high levels of gamma globulin noted in this and other laboratories also indicate that there is an excessive production of these substances. The relative absence of eosinophils is compatible with a continuous or repeated stress reaction. The most critical questions, however, are: a) What is the antigen; and, b) How does it enter the body? The answer to the first is not known at the present time. But, because of the occurrence of the "nephrosis peptide" and the possibilities of determining its chemical nature and origin there is hope of identification of its source. As far as the means of entry of antigen into the body are concerned this is considerably simpler. It is known[10] that infants absorb some proteins through the gastrointestinal wall without alteration, i.e., egg albumin, blood plasma, etc. These proteins are generally not used by the body but are excreted, unchanged, through the urine. In the course of the state program for testing for phenylketonuria it has been found that approximately two per cent of all infants have albuminuria at the time of the single test, about 40 per cent of whom have more than a "trace". No symptoms have been noted to accompany albuminuria and it is probably the result of absorption of protein. Combining these two sets of data, approximately 0.8 per cent of infants absorb and excrete significant quantities of proteins from the gastrointestinal tract.

With this knowledge a reasonable hypothesis for the occurrence of sudden death can be advanced. About one per cent of all infants absorb significant quantities of unaltered proteins

from the gastrointestinal tract. Some of the proteins absorbed are antigenic. Protection against the reactions elicited by the antigenicity of these proteins is provided by passively received antibodies from the mother during approximately the first three months of life. With the disappearance of these passively received antibodies at a time prior to the development of full efficiency of the baby's own immunologic system the absorbed antigenic proteins for an indeterminate period of time are allowed to exert their actions unopposed. When, through the coincidence of exposure to proteins which can be absorbed at that moment in their existence when they are not protected by maternal antibodies the babies do absorb a significant quantity of antigen, an anaphylactic reaction results. What influences excessive absorption is not known. It is known, however, that alterations in the motility of the gastrointestinal tract alter absorption.[11] It is further known that the infant's gastrointestinal tract is notoriously variable in its motility, and it reacts to distant stimuli with a violence not seen in older individuals. Although infection of any significant degree has not been found to be a cause of sudden death in infancy, in many of the infants minor, microscopic, inflammatory lesions have been described. It is possible that although such lesions were of such minimal extent that they gave rise to no symptoms per se they nevertheless were sufficient to excite a generalized physiologic reaction in the infant, especially of the gastrointestinal tract.

Having arrived at such a conclusion the logical question is a pragmatic one best stated as "So what?" From the evidence presented infants liable to such a chain of events could be identified simply by continuous testing of their urine for the presence of albuminuria. At the present time, though expensive, for example it would be possible to place a paper strip in each clean diaper and observe a color change. In infants who manifest proteinuria on more than one occasion it would be desirable to adjust the diet so that none of the offending proteins were present, or to provide pharmacologic antidotes. That infants dying suddenly and unexpectedly do manifest proteinuria at one time or another prior to death is attested to by a singular instance provided to the author by a singularly qualified observer. The baby's mother was a board certified pediatrician who, for reasons not apparent to other observers, suspected that "something was wrong" with her child. After exhaustive investigation at an outstanding pediatric center the child was declared well. It had, however, been noted during the period of hospitalization that the child had an intermittent albuminuria and after discharge the mother, on four occasions, also tested for and noted albuminuria. The infant was found dead at the age of two months. Examination of the infant revealed anatomic lesions essentially as described above.

Conclusion

Sudden, unexpected death is essentially one of an anaphylactic nature. The cause of the anaphylaxis is a protein absorbed from the gastrointestinal tract. The absorption of this protein from the gastrointestinal tract is determined by three factors:

a. A physiologic defect in the infant which allows him to absorb unaltered protein.
b. The presence of the protein in the diet.
c. The occurrence of incidental events, i.e., infections, which might affect gastrointestinal motility and the probability of absorption of various substances from the gastrointestinal tract.

Because the infant absorbs antigenic proteins his immunologic mechanisms are worked to their fullest degree, as manifested by high levels of gamma globulin, and the organ responsible for the initiation of such mechanisms, the thymus, undergoes compensatory hyperplasia. Death results from anaphylactic reaction following insufficiency of neutralizing antibody as the result of the natural loss of passively received maternal antibodies. Infants susceptible to this type of death can be identified by the presence of intermittent albuminuria and by radiologic evidence of a large thymus. In theory it would be possible to remove the antigenic stimulus from the diet, or pharmacologically prevent these anaphylactic deaths.

Summary

1. Sudden, unexpected death in infancy is a medical problem of major proportions. It ranks as the tenth most common cause of death of all persons. Data, admittedly insufficient, indicates that such death occurs in one of every 200 infants.

2. The anatomic manifestations are diffuse emphysema of the lungs, pulmonary edema, occasional petechial hemorrhages; hyperplasia

of the thymus; swelling of glomerular tuft apparently due to edema of the mesangial cells occasionally associated with swelling of the arterioles and degeneration of the distal tubules; similar alterations are seen in the liver and spleen; there is an absence of eosinophils from their usual sites.

3. No infectious agents have ever been identified.

4. A finding present in every infant dying suddenly and unexpectedly is a massive albuminuria together with a chromatographically identified, abnormal substance known as a "nephrosis peptide".

5. The disease coincides with the disappearance of maternal antibodies from the infant.

6. The anatomic characteristics of the reaction are compatible with those seen in anaphylaxis.

7. The cause of the anaphylaxis is probably a protein absorbed from the gastrointestinal tract.

8. Infants susceptible to this type of death can be identified by the presence of intermittent albuminuria and radiologic evidence of an enlarged thymus.

9. Theoretically, infants who manifest albuminuria and an enlarged thymus could be identified and treated and such deaths could be avoided.

References

1. Stowens, D. *Sudden Unexpected Death in Infancy.* Am. J. Dis. Child, 94: 674-681, 1957.
2. Werne, J. and Garrow, I. *Sudden Unexpected Death.* A. J. Path., 29:817, 1953.
3. Leys, D. *Inheritance of a Factor Causing Sudden Death in Childhood and Early Adult Life.* Edinburgh Medical Journal, London, 1950, 57: 1-16.
4. Parish, W. E., et al. *Hypersensitivity to Milk and Sudden Death in Infancy.* Lancet, 2: 1106-1110, Nov. 19, 1960.
5. Spain, D. N., et al., *Sudden Death.* J.A.M.A., 1954, 156-246.
6. Valdes-Dapena, M.A., et al. *Sudden and Unexpected Death in Infants, I. Gamma Globulin Levels in the Serum.* J. Pediatrics (2)63: 290-294, Aug. 1963.
7. Hammar, J. A. *Die Menschenthymus in Gesundheit und Krankheit.* Tell 1: *Das Normale Organ.* 2. mikrosk. — anat. F korsch. 6: Suppl. 1926.
8. Feldman, J. D., et al. *Experimental Glomerulonephritis,* III. *Pathogenesis of Glomerular Lesions in Nephrotoxic Serum Nephritis.* Lab. Invest. 12 (no. 7): 748-763, July 29, 1963.
9. Schloss, O. M. and Worthen, T. W. *The Permeability of the Gastroenteric Tract of Infants to Undigested Protein.* Am. J. Dis. Child., 11: 342, 1916.
10. Gruskay, F. L. and Cooke, R. E. *The Gastrointestinal Absorption of Unaltered Protein in Normal Infants and in Infants Recovering from Diarrhea.* Pediatrics, 1955, 16: 763.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations, with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Janet Ave., Louisville, Kentucky 40205.

SPECIAL ARTICLES

50 Years in The Practice of Medicine in Georgetown

HENRY V. JOHNSON, M.D.
Georgetown, Kentucky

THE following account, I trust, will not apppear egotistical, but simply a record to show how medicine and sanitation have advanced and improved in Georgetown in the last 50 years.

I was graduated from the Medical School of the University of Colorado in 1906 and served twelve months as an intern in the Denver and Rio Grande Railroad Hospital, where I was allowed to do a minimum amount of surgery. Doctor John Roe, who was afterward Chief Surgeon of the D. & R.G., and Doctor Connell, who originated the Connell intestinal sutures, were resident surgeons. They were two of the most skillful surgeons I ever saw.

Coming to Georgetown in September, 1907, I went to the office of Doctor John A. Lewis and Doctor W. H. Coffman. I borrowed $15 from my uncle, Judge George Payne, president of the Farmers' Bank, to buy a license to practice medicine. Doctor and Mrs. Coffman gave me my meals and a room over the office, otherwise I would have starved to death.

This was eight years before we built the John Graves Ford Memorial Hospital, and we operated in kitchens, bedrooms, dining rooms, etc. Doctor Scott, the City Health Officer, had just died and the City Board, composed of John Downing, Judge Thacker, and Ben A. Lair, Sr., appointed me as City Health Officer.

We had no filtration plant, and were pumping water out of the head of the spring. The water got low and we had a terrible epidemic of typhoid fever and lost many of our valuable citizens. On top of that, we had an epidemic of small-pox, and at one time I was treating 30 cases of this disease.

Doctor J. N. McCormack, State Health Officer and father of Doctor Arthur McCormack, came up to make an inspection. When he finished, he said, "Harry, it is not the fault of the spring, but the people who have built around it and are pouring their sewage into the branch." We ordered a vote to issue bonds and build a purification plant. It looked for a time as though the vote would not carry, but due to some influential men, it went over.

In 1920 we decided to have a full-time Health Department. We asked the Fiscal Court, composed of J. R. Lancaster, Fred Aulick, Tom Shuff, and Hedge True, to make the appropriation for $5,000, and the State was to put up the same amount. This was a very unpopular move, but due to our friends, the Court voted the amount. That was the start of the Scott County Health Department, which had now sold itself to the citizens of Scott County.

The next Fiscal Court refused to make the necessary $5,000 appropriation and allowed only $2,500; that was when our friends, headed by Mrs. Doctor Coffman, Anderson Brown and others, raised the other $2,500 and the unit continued. "Ma" Adams was one of the first Visiting Nurses and did a wonderful job for the people. She was second to Miss Hunt, who had been a nurse for the Health and Welfare Association. Doctor Coffman was chairman of the Board until his death in 1925. I then served as chairman of the Board until 1950, when I resigned to act as part-time Health Officer and allow the Fiscal Court to make the appropriation and Doctor Fred Wilt was elected chairman.

In addition to typhoid and small-pox, we had epidemics of influenza; the worst was in 1918. The infection was probably brought into Kentucky by the troops being sent from Texas to Port of Embarkation.

The first case I saw was a student from Hopkinsville who came to me with a temperature of 104 degrees. I put him in the hospital for a week and the next week I was down with it. The college students fell like the leaves from a tree. It spread all over town and many died from flu-pneumonia.

Whooping cough was the bane of my existence and many children developed bronchiectasis as a result. Diptheria antitoxin was in its infancy; many were afraid of it. They would postpone vaccination until a tracheotomy had to be performed.

An appendectomy was considered a most serious operation and it was, because most of the cases were diagnosed as "inflammation of the bowels", which of course they had after the appendix ruptured and peritonitis set in. I saw one case, with Doctor John A. Lewis, on whom Doctor Lewis did an end-to-end anastomosis. He lived about three days after the operation. I have always said there was never an appendix taken out too early, but many came out too late.

Following the flu epidemic of 1918 we had a number of cases of empyema; we resected a rib and put in a drainage tube with fairly good results.

Before we built the hospital, we did obstetrics under all sorts of conditions, with very poor help as a rule. The mothers had practically no prenatal care, and would often wait until the last minute to call a doctor. Feather-beds were a nuisance; sometimes it was hard to find the patient. The Cincinnati Enquirer was used instead of a rubber sheet, and why we did not have

more puerperal sepsis, I do not know.

Venereal diseases were quite prevalent, and were treated with Mercury, Potassium iodide and irrigation. We had no laboratory and patients were sent to Cincinnati for a Wasserman. There was no premarital examination or blood-test. Now we examine the couple, test their blood, wait three days, and then they may buy a license.

In 1908 we had only two Pasteur Institutes in the United States, and anyone bitten by a rabid animal had to go to New York or Chicago for treatment. I took one patient to Chicago, where he stayed for 21 days, getting a shot every day. Later on we sent our patients to Bowling Green, where the state laboratory was held for treatment. A man came into my office one day and asked me if I had a "Mad Stone". I had never heard of one, and he told me that you put it on the bite and if it turned green the animal was rabid. Maybe he was right.

"Ma" Adams and I used to examine the school children and it seemed to me that half of them were infected with the "Itch". We applied sulphur and lard and soon they were well. We also found *pediculosis capitis,* or head lice, but today that is a rarity. These good results are all due to education and more sanitary living conditions.

Infant feeding was one of our big problems. We tried to have the mother nurse the baby, but if that was not practical we hunted for a wet nurse. They were hard to find, and we turned to artifical feeding. Many babies were underfed and lost because of our lack of knowledge. The milk we give them today is a different product from the old formula.

Osteomyelitis was a rather common disease. I remember one boy who had an infection of the tibia; we operated several times and finally had to amputate above the knee. He got well and is now living in Georgetown and seems perfectly well.

Due to impure milk and water, summer diarrhea and "second summer complaint" kept us busy. This condition has now become rare.

Another trouble we had was malaria; mosquitos were quite prevalent and no one paid any special attention to them. We loaded the patients up on quinine until their ears rang. Measles, mumps, and tonsilitis were taken as a matter of course and treated accordingly.

Our method of transportation in those days was rather slow but sure. All of us drove horses and buggies. Some kept two horses; some kept three. When Maria and I married we lived on Jackson Street, and I kept my horse in the stable there. I rigged up a rope and pulley arrangement like the fire department used, so that I could raise the harness off the horse. When called at night I backed the horse under the shafts, dropped the harness and was ready to go, all in a few minutes. We had no paved streets, but had stepping stones at the corners and you had to hit them just right in muddy weather or it would almost throw you out of the buggy.

I have been president of the Scott County Medical Society and president of the Kentucky Midland Medical Society and Delegate from our county to the State Medical Association a number of times. I served for 12 years as secretary of the Scott County Medical Society. During that time we had a perfect record of meetings, once a month.

In 1909 we had no shortage of medical men in Scott County. There were two at Sadieville, two at Stamping Ground, one at Newtown, one at Minorsville, one at Payne's Depot, and plenty in Georgetown. Our fees were very small in the olden days; a house visit to a Negro was $1.00, to a white man, $1.50. Obstetrics was never over $25. Laparotomies $100 or less. My first year I grossed $300 and was out of balance 30 cents, which I have never caught up with.

Our experiences, in the early days, were varied, but there is one incident which stands out in my mind. A man died near Sadieville, and the family suspected poison and wanted his stomach analyzed. Judge H. C. Ford was County Attorney. Judge Ford, Mig Fleming, the Sheriff, and Oak Prather, the chauffeur, drove down and found the funeral about to begin. We took the body out of the casket put it on the kitchen table. I removed the stomach, sewed up the corpse, and the funeral went on.

In 1911 I began my postgraduate work, which started at the Post-Graduate Hospital in New York City. The next year I took a course at the Laboratory of Surgical Technique in Chicago. I went there three times, where we operated on live dogs, under anesthesia, and did everything from goiter to gall-bladders. Our clinics were held at the Augustana Hospital, which was founded by the Ochner Brothers. Later on, I went to the Mayo Clinic in Rochester and was there three times. In 1918 I volunteered in the Medical Corps of the U. S. Army and was sent to Fort Oglethorpe, Georgia, for training. I only served a short time and came home to practice again.

Doctor Coffman died in 1925. We then had a hospital, where Doctor D. B. Knox and I did most of the surgery. Doctor Knox was a skillful surgeon and was well thought of by his many friends.

Georgetown now has a modern hospital, with a fine laboratory, modern x-ray equipment, a most excellent director, and a corps of skilled nurses. We also have a water purification plant second to none, a most efficient full-time Health Department, responsible for sanitation, the immunization and examination of the school children. Our sewage disposal plant is preventing contamination of the water in Elkhorn Creek. Instead of 14 dairies, with milk unfit for human consumption, we now have sanitary dairies supplying us with good milk. Our Council members, headed by Mayor Harry Paxton, are serving the city and are always willing to hear constructive criticism. The Police Department, headed by Chief Billy Platt, is doing a wonderful job in protecting the interest of our citizens and controlling traffic. We have a Volunteer Fire Department, on the job 24 hours a day, and have not had a serious fire in years. Our grade schools, high schools, and the College have made wonderful improvements in the last few years.

We who have devoted our efforts to the improvement of our community during the past half-century find our reward—Georgetown is a beautiful city of the Bluegrass—and more, it is a safe and comfortable place to live and raise our families.

EDITORIALS

Thanks

THE Christmas Season provides the Editors of our Journal the opportunity to thank the many individuals for their scientific contributions and the companies that have supported the Journal by the purchase of advertising space, thus contributing to its success during the past year.

Among those to be thanked are the authors of the scientific and educational articles. The number of scientific articles submitted to the Journal for publication during the past year was sharply increased over previous years. In many instances the quality of the articles improved as well.

Many physicians and others throughout the Commonwealth have contributed special articles and news items that have helped the Journal serve its varied functions.

To the national and local companies and institutions that have used the Journal for advertising during the past year, the Editors wish to express their sincere appreciation and to offer the Season's Greetings.

Walter S. Coe, M.D.

We Wish You

A Very Pleasant Holiday Season

Sam A. Overstreet, M.D., Editor

and

The Journal Staff

In Flanders Fields ***

John McCrae

In Flanders fields the poppies blow
Between the crosses, row on row,
That mark our place; and in the sky
The larks, still bravely singing, fly
Scarce heard amid the guns below.

We are the Dead. Short days ago
We lived, felt dawn, saw sunset glow,
Loved and were loved, and now we lie,
In Flanders fields.

Take up our quarrel with the foe:
To you from failing hands we throw
The torch; be yours to hold it high.
If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders fields

* *(C) PUNCH, London*
** *This tribute is printed in memory of the 57 Kentucky physicians who passed away during the past year. See following page for complete list.*

Deceased Kentucky Physicians
1964*

F. T. Adams, M.D., Covington
John G. Archer, M.D., Prestonsburg
Alva Glenn Barton, M.D., Louisville
Charles K. Beck, M.D., Louisville
Maurice Bell, M.D., Eminence
John A. O. Brennan, M.D., Louisville
Beverly S. Broaddus, M.D., Irvine
C. C. Burton, M.D., West Liberty
William P. Cawood, M.D., Harlan
M. M. Collins, M.D., Lackey
J. W. Conway, M.D., Morganfield
Gilbert A. Cook, M.D., North Middletown
Vincent Corrao, M.D., Munfordville
Thomas J. Crume, M.D., Owensboro
Oscar T. Davis, M.D., Hopkinsville
G. P. Dillon, Jr., M.D., Louisville
Lester C. Dodson, M.D., Owensboro
F. J. Eakins, M.D., Robards
Raymond M. Evans, M.D., Louisville
Ernest M. Ewers, M.D., Somerset
J. E. Esteves, M.D., Warsaw
James W. T. Fuller, M.D., Mayfield
G. B. Froage, M.D., Paducah
Charles E. Gaupin, M.D., Louisville
Casey B. Graves, M.D., Morganfield
Edward P. Guerrant, M.D., Winchester
Harvey C. Hardegree, Jr., M.D., Louisville
Robert D. Higgins, M.D., Ashland
Emmet F. Horine, M.D., Brooks
William P. Humphrey, M.D., Sturgis
James G. Hutchinson, M.D., Louisville
William T. Jessee, M.D., Plummer's Landing
J. E. Johnson, M.D., South Williamson
M. M. Jones, M.D., Lexington
W. K. Kannard, M.D., Louisville
Robert E. Kennedy, M.D., Harlan
Earl Scott Lewis, M.D., Mouthcard
Emmett H. Miller, M.D., Vine Grove
Charlton A. Macpherson, M.D., Louisville
John C. Morrison, M.D., Hickman
John R. Nurse, M.D., Louisville
W. F. O'Donnell, Jr., M.D., Hazard
Albro L. Parsons, M.D., Louisville
Thomas A. Pease, M.D., Cunningham
Frank L. Peddicord, M.D., Louisville
Virgil L. Powell, M.D., Paducah
George Purdy, M.D., New Liberty
George L. Richardson, M.D., Adairville
Fred W. Rulander, M.D., Louisville
James A. Ryan, M.D., Covington
Perry C. Sanders, M.D., Danville
Leonard E. Stinson, M.D., Benton
Mack Whitis, M.D., East Bernstadt
C. A. Wood, M.D., Auburn
John P. Wyles, M.D., Cynthiana
Martin A. Yelton, M.D., Burlington
John P. Walton, M.D., Alexandria

** List of names of deceased physicians available to The Journal as of November 20, 1964.*

The A. D. Price Memorial Meeting of The Kentucky State Medicial Association

Terrace Room, Kentucky Hotel, Louisville, Kentucky, September 28-October 1, 1964

Digest* of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Garnett J. Sweeney, M.D., Liberty
Speaker of the House, Presiding

First Session

Doctor Sweeney called the meeting to order and asked Homer B. Martin, M.D., Louisville, to give the invocation. Norma Shepherd, M.D., Hopkinsville, a member of the Credentials Committee, reported that a quorum was present. It was moved and seconded that the minutes of the 1963 meeting be accepted as published in The Journal. The motion carried.

The KSMA Secretary, Henry B. Asman, M.D., presented the general announcements. He stated that the opening ceremonies for the general scientific session would begin at 9:00 a.m. Tuesday, September 29 at the Convention Center. Doctor Asman announced that Charles Jarvis, D. D. S. of San Marcos, Texas would be delivering the address at the President's Luncheon on Wednesday, September 30.

The Secretary read the list of physicians who had died since the 1963 meeting and the House stood for a moment in silence in their memory. The names of the physicians, their location and date of death are as follows:

Adams, F. T., Covington, August 1964
Archer, John G., Prestonsburg, July 4, 1964
Beck, Charles K., (Emeritus), Louisville, January 25, 1964
Bell, Maurice, Eminence, August 26, 1964
Brennon, John A. O., Louisville, Sept. 1, 1964
Brewster, Glenn W., Hustonville, (In Cincinnati), Dec. 5, 1963
Broaddus, Beverly S., (Emeritus), Irvine, Jan. 16, 1964
Burton, C. C., West Liberty, May 31, 1964
Clark, Edgar R., Louisville, Nov. 24, 1963
Collins, M. M., (Emeritus), Lackey, Jan. 24, 1964
Combs, Pearl B., Dwarf, (Out of State), Nov. 3, 1963
Conway, J. W., (Emeritus), Morganfield, May 16, 1964
Corrao, Vincent, Munfordville, August 1964
Cosby, Ira D., (Emeritus), Henderson, Nov. 9, 1963
Crume, Thomas J., (Emeritus), Owensboro, Apr. 26, 1964
Davis, Oscar T., Hopkinsville, Aug. 11, 1964
Dillon, G. P. Jr., Louisville, Aug. 16, 1964
Dodson, Leslie C., Owensboro, July 21, 1964
Eakins, F. J., Robards, July 1964
Ellis, Stephen R., (Member), Louisville, Dec. 1, 1963
Evans, Raymond M., (Emeritus), Louisville, Apr. 15, 1964
Ewers, Ernest M., (Emeritus), Somerset, 1964
Esteves, J. E., (Member), Warsaw, Sept. 20, 1964
Froage, G. B., Paducah, July 31, 1964
Gaupin, Charles E., Louisville, March 21, 1964
Graves, Casey B., (Emeritus) Morganfield, Nov. 16, 1963
Guerrant, Edward P., Winchester, June 17, 1964
Hall, John C., Ashland, Oct. 18, 1963
Hardegree, Harvey C. Jr., (Member), Louisville, September 8, 1964
Harrell, J. F., Bardwell, (Out of State), August 1964
Hodges, Stuart, Alva, (Out of State), Oct. 6, 1963
Horine, Emmet F., (Emeritus), Brooks, Feb. 1, 1964
Hoskins, Albert B., (Emeritus), Beattyville, Dec. 9, 1963
Hutchinson, James G., (Emeritus), Louisville, Apr. 30, 1964
Johnson, J. E., South Williamson, July 20, 1964
Jones, Beverly P., Barbourville, Nov. 28, 1963
Kannard, W. K., Louisville, September 16, 1964
Kennedy, Robert E., Harlan, January 1964
Kimber, Karl E., Ashland, Oct. 26, 1963
Lawrence, Marshall M., (Member), Jamestown, Oct. 9, 1963
Lewis, Earl Scott, (Member), Mouthcard, June 23, 1964
Meece, Grover C., (Member), Whitley city, Oct. 16, 1963
Miller, Emmett H., Vine Grove, Mar. 11, 1964
Morrison, John C., (Member), Hickman, June 10, 1964
Neblett, Lamar W., (Member), Louisville, Oct. 24, 1963
Nurse, John R., Louisville, Aug. 6, 1964
Owens, Walker, (Emeritus), Mt. Vernon, Dec. 5, 1963
Pauli, Augustus J., (Member), Louisville, Dec. 18, 1963

**Editorial Note: A tape recording was made of the two sessions of the House of Delegates, and any member who desires to examine the transcript of the proceedings, may come to the headquarters office and listen to the recording.*

Peddicord, Frank L., (Emeritus), Louisville, Apr. 9, 1964
Raike, Ellis E., Greenup, Nov. 2, 1963
Richardson, George L., (Member), Adairville, Apr. 22, 1964
Robbins, Ballard F., (Member), Berea, Nov. 4, 1963
Rulander, Fred W., Louisvlle, July 28, 1964
Ryan, James A., Covington, Jan. 18, 1964
Sanders, Perry C., Danville, September 10, 1964
Scrivner, Samuel T., (Member), Stanton, Oct. 30, 1963
Stambaugh, Harry G., Ashland, (Out of State), Nov. 30, 1963
Stinson, Leonard E., Benton, September 2, 1964
Weber, Jacob, (Emeritus), New Albany, Ind., Nov. 26, 1963
Whitis, Mack, East Bernstadt, May 24, 1964
Wood, C. A., Auburn, Aug. 13, 1964
Wyles, John Peter, Cynthiana, Jan. 20, 1964
Yelton, Martin A., Burlington, June 30, 1964
Zinn, Newton G., Alexandria, Dec. 8, 1963
Walton, John P., (Emeritus), Central City, September 22, 1964
O'Donnell, W. F., Jr., (Member), Hazard, September 24, 1964

The Speaker announced the reference committee appointments as follows:

Reference Committee No. 1—Reports of Officers and Board of Trustees

Ballard W. Cassady, M.D., Pikeville, Chairman
Glenn W. Baird, M.D., Bandana
Walter L. Cawood, M.D., Ashland
Paul J. Ross, M.D., Louisville
George H. Widener, Jr., M.D., Paducah

Reference Committee No. 2—Scientific Assembly and Medical Education

W. Gerald Edds, M.D., Calhoun, Chairman
Richard A. Allnutt, M.D., Covington
Walter O'Nan, M.D., Henderson
Robert A. Orr, M.D., Mayfield
Samuel D. Weakley, Jr., M.D., Louisville

Reference Committee No. 3—Legislative Activities

Homer B. Martin, M.D., Louisville, Chairman
Harold B. Barton, M.D., Corbin
M. C. Loy, M.D., Columbia
James G. Sills, M.D., Hardinsburg
David B. Stevens, M.D., Lexington

Reference Committee No. 4—Public Service and Allied Professions

Paul H. Klingenberg, M.D., Covington, Chairman
William E. Becknell, M.D., Manchester
Andrew M. Moore, M.D., Lexington
Paul J. Sides, M.D., Lancaster
B. H. Warren, M.D., Owensboro

Reference Committee No. 5—Medical Service

David W. Kinnaird, M.D., Louisville, Chairman
Walter L. Boswell, M.D., Lexington
Carl J. Brueggemann, M.D., Covington
David D. Drye, M.D., Bradfordsville
Claude C. Waldrop, M.D., Williamstown

Reference Committee No. 6—Constitution and Bylaws; Special Committees

N. Lewis Bosworth, M.D., Lexington, Chairman
J. S. Baughman, M.D., Harrodsburg
Donald Graves, M.D., Frenchburg
Ralph D. Lynn, M.D., Elkton
Henry W. Post, M.D., Louisville

Reference Committee No. 7—Miscellaneous

L. F. Beasley, M.D., Franklin, Chairman
W. B. Haley, M.D., Paducah
Charles E. Peck, M.D., Russell Springs
Joseph Saunders, M.D., Lexington
Hylan H. Woodson, M.D., Greenville

Doctor Sweeney announced that the tellers for the meeting would be M. R. Gilliam, M.D., Lexington; B. B. Baughman, M.D., Frankfort; W. C. Gettelfinger, M.D., Louisville; and Russell L. Hall, M.D., Prestonsburg.

The Speaker stated that alternates might be needed to serve on the reference committees when they convened at 2:00 on Monday, September 28 on the fourteenth and fifteenth floors of the Kentucky Hotel. He asked that the following physicians should they desire to fill possible vacancies to be on the fifteenth floor of the Kentucky Hotel at 2:00 that afternoon:
Owen Davis, M.D., Scottsville
M. J. Evans, M.D., Middlesboro
Ralph Cash, M.D., Princeton
Robert T. Longshore, M.D., Covington
Gene T. Watts, M.D., Hindman
J. C. Cantrill, M.D., Georgetown
J. M. Stevenson, M.D., Brooksville
T. R. Bryant, Jr., M.D., Lexington
Mary Pauline Fox, M.D., Hazard

Doctor Sweeney also announced that the KSMA Delegates and Alternate Delegates to the AMA had been assigned to the KSMA Reference Committees and would be serving as resource people during the committee hearings.

The reports of the officers and committees were presented at this time and referred to the respective reference committees by the Speaker as follows:

Report of the President—Reference Committee No. 1

Report of the President (Page three numbered paragraph two and the numbered paragraph seven on page four)—Reference Committee No. 2

Report of the President, Woman's Auxiliary to KSMA—Reference Committee No. 1

Report of the President-Elect—Reference Committee No. 1

Report of the Speaker of the House—Reference Committee No. 1

Report of the Chairman, Board of Trustees—Reference Committee No. 1

The Speaker then recognized William Bizot, M.D., the chairman of the Awards Committee, for his nominations for the Distinguished Service Medal, and the Outstanding General Practitioner Award. G. L. Simpson, M.D., Greenville, was nominated for the Distinguished Service Medal. A motion was made, seconded and carried that Doctor Simpson be the recipient of this award.

Doctor Bizot then placed the name of Lloyd M. Hall, M.D., Salyersville, in nomination to be the recipient of the Outstanding General Practitioner Award. The motion was seconded and carried.

The Speaker of the House then introduced Mrs. Bettye Fisher of Evansville, Indiana, a past president of the American Association of Medical Assistants. Following the brief address by Mrs. Fisher, which was well received, the House recessed for fifteen minutes. The Kentucky State Association of Medical Assistants provided coffee.

After reconvening the House, Doctor Sweeney continued with the assignment of the reports to the various reference committees as follows:

Report of the Secretary—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Treasurer—Reference Committee No. 1

Report of the Delegates to the AMA—Reference Committee No. 1

Report of the Executive Secretary—Reference Committee No. 1

Report of the Council on Scientific Assembly—

Reference Committee No. 2

Report of the Council on Medical Education and Hospitals—Reference Committee No. 2

Report of the Council on Legislative Activities——Parts I and II—Reference Committee No. 3

Report of the Council on Medical Services—Reference Committee No. 5, except that the entire report of the Medical Discipline Committee on page 3 including its nine recommendations and the proposed amendments to the KSMA Bylaws beginning on page 19 will be referred to Reference Committee No. 6

Report of the Council on Communications and Public Service—Reference Committee No. 4, except that on page 6 numbered paragraph 10 and the Board action on page 17 will be referred to Reference Committee No. 3

Report of the Council on Allied Professions and Related Groups—Reference Committee No. 4, except that fifth and sixth paragraphs on page 3 of this report will be referred to Reference Committee No. 3.

Report of the Advisory Committee to the Editor—Reference Committee No. 6

Report of the Professional Relations Committee—Reference Committee No. 6

Report of the Committee on Third Party Medicine—Reference Committee No. 6

Report of the Committee to Study the Constitution and Bylaws—Reference Committee No. 6

The Speaker of the House recognized James M. Riley, M.D., chairman of the Jefferson County Delegation. Doctor Riley stated that the Jefferson County Delegation was submitting an amendment to the Report of the Committee to Study the Constitution and Bylaws dealing with indoctrination. Doctor Sweeney referred this amendment to Reference Committee No. 6.

Report of the Interim Meeting Program Committee—Reference Committee No. 6

Report of the Insurance Review Board—Reference Committee No. 6

Report of the Board of Directors, Kentucky Physicians Mutual, Inc., Reference Committee No. 5

The Chairman of the Medical Services Committee, Doctor Pierce, read the addendum to the report of the Board of Directors of Kentucky Physicians Mutual, and the Speaker of the House referred this to Reference Committee No. 5.

Report of the Board of Trustees, Rural Kentucky Medical Scholarship Fund, Reference Committee No. 5

Report of the McDowell Home Committee—Reference Committee No. 7, except the third paragraph on page 4 beginning with the words "it is a matter of pride . . ." and the attached financial report will be referred to Reference Committee No. 1.

Report of the Memorials Commission—Reference Committee No. 7

Report of the Technical Advisory Committee on Indigent Medical Care—Reference Committee No. 5

Report of the KSMA Representative to Conference of Presidents and Other Officers of State Medical Associations—Reference Committee No. 7

Report of KSMA Representative, U. of K. Chapter, Student AMA—Reference Committee No. 7

Report of KSMA Representative, U. of L. Chapter, Student AMA—Reference Committee No. 7

Report of KSMA Representative on Kentucky Poison Control Program—Reference Committee No. 6

Report of the Advisory Committee to Selective Service—Reference Committee No. 5

Report of Representative, Advisory Committee on Maternal and Child Health, State Department of Health—Reference Committee No. 7

Report of the Representative, Kentucky Mental Health Planning Commission—Reference Committee No. 5

New Business

The new business was then presented to the House and referred to the reference committees by the Speaker as follows:

(A) Resolution of KSMA Committee on Disaster Medical Care concerning Hospital Signs on Highways—Reference Committee No. 5

(B) Resolution of Muhlenberg County Medical Society on the subject of Social Security Coverage for Physicians—Reference Committee No. 3

(C) Resolution of Jessamine County Medical Society concerning Straight Internships vs. Rotating Internships. J. S. Williams, M.D., the delegate from Jessamine County submitted a correction in the first resolved of the resolution substituting the word "exclusively" for "per se". The Speaker of the House referred this resolution as corrected to Reference Committee No. 2.

(D) Resolution of Campbell-Kenton County Medical Society on the subject of Private Hospital Internships—Reference Committee No. 2

(E) Resolution of Campbell-Kenton County Medical Society concerning Appointment of Dr. E. Annis, M.D.—Reference Committee No. 1

(F) Resolution of Campbell-Kenton County Medical Society relating to Participation in New Third Party Plans—Reference Committee No. 5

Doctor Sweeney recognized Wyatt Norvell, M.D., New Castle, AMA Delegate, who presented the following resolution to the members of the House:

WHEREAS, Norman A. Welch, M.D. died in Wyoming while carrying out his official duty as President of the American Medical Association,

WHEREAS, he had so well and unselfishly devoted his God-given abilities and attributes of leadership as Speaker of the House of Delegates, President-Elect and for such a short period of time, as President of the American Medical Association,

WHEREAS, he so well exemplified in deeds his own words as expressed in his inaugural address that medicine must be united "to serve the public in the future to the high degree that it has in the past"

WHEREAS, he had for many years been active in financing medical care for the people of his home state and distinguished himself both as a member of the Board and as President of the National Conference of Blue Shield Plans,

WHEREAS, Norman A. Welch, M.D. was truly a worthy example of Robert Louis Stevenson's "A Tribute to a Physician", and,

WHEREAS, he will be sorely missed by his many local friends in Kentucky.

THEREFORE, NOW BE IT RESOLVED that the members of this House of Delegates record its grief on the passing of this great American physician and express its warmest sympathy to his lovely and loyal wife and to his children.

The members of the House of Delegates adopted this resolution by a standing vote.

The meeting places for the Nominating Committee for general officers and the six Trustee Districts were announced by the Executive Secretary. He stated that the Nominating Committee would report immediately at the close of the first scientific session on Tuesday morning at the Convention Center, and these nominations would again be read at the second meeting of the House on Wednesday, when according to the Bylaws, additional nominations could be made from the floor without discussion or comment.

With there being no further business, the meeting adjourned at 12:15 p.m.

Second Session

The second session of the House of Delegates was called to order on September 30, 1964 by the Speaker Garnett J. Sweeney, M.D. E. C. Seeley, M.D., London, gave the invocation.

The Chairman of the Credentials Committee, Harvey Chenault, M.D., reported that a quorum was present.

The Speaker recognized the Chairman of the Board of Trustees, Douglas E. Scott, M.D., who presented the final report of the Board of Trustees as follows:

The Board of Trustees submits the following resolution, passed at its September 30 meeting:

"WHEREAS, the 1964 KSMA Annual Meeting has made a substantial contribution in the field of continuing medical education and its program has been well received, and

"WHEREAS, many individuals, organizations, and agencies including our guests and the essayists from our State, the scientific and technical exhibitors, the sponsors of the Message Center, the newspapers, radio and television stations, the hotels, and the Convention Center, have contributed greatly to its success, and

"WHEREAS, the Trans-Atlantic CPC sponsored by Smith, Kline and French has again made a fine contribution to our meeting, now

"THEREFORE BE IT RESOLVED, that this House of Delegates goes on record as expressing its deepest appreciation to all individuals and organizations who have had a part in the development and implementation of the 1964 Annual Meeting."

Doctor Scott moved the adoption of the resolution. The motion was seconded and carried.

Doctor Asman presented the announcements. He recognized O. B. McGillicuddy, M.D., Lansing, Michigan, president of the Michigan State Medical Society and E. A. Piszczek, M.D., Chicago, president of the Illinois State Medical Society.

The reports of the Reference Committees were then presented.

† *In order to make the Digest of Proceedings of the second meeting of the House of Delegates more understandable and because it will occupy less space in The Journal, the KMA Board of Trustees passed the following motions "That if no dissenting action on the committee's recommendations is made either by the Council under which the committee serves or the KMA Board of Trustees, only the reference committee action on the report be printed in The Journal."*

REFERENCE COMMITTEE NO. 1 †

Ballard W. Cassady, M.D., Chairman

Reports of Officers and Board of Trustees

Reference Committee No. 1 considered the following reports:

1. Report of the President
2. Report of President, Woman's Auxiliary to KSMA
3. Report of President Elect
4. Report of Speaker of the House
5. Report of Chairman of Board of Trustees
6. Report of the Secretary
7. Report of the Editor
8. Report of the Treasurer
9. Report of the AMA Delegates
10. Report of Executive Secretary
25. Report of the McDowell Home Committee

Resolution E — Appointment of Dr. E. Annis, M.D.

Report of the President

One of the major objectives of my administration has been to communicate to each member of the Association as clear an understanding as possible of what his KSMA is doing for him in all of the various areas of activity, scientific, economic and political. We have an organization we can be proud of.

If any one of you wants to take issue with that statement, we would urge you to carefully review each of the approximately 225 pages in our House of Delegates folders, which relate to the sixty-odd reports submitted by our officers, Board, and councils and committees. Then, we are convinced, you will agree with me that we have had an excellent year in KSMA.

It will not be possible here to mention progress on all the various fronts during the past year; however, we would like to mention a few.

We have, at this writing, the largest number of paid members in the history of KSMA, despite the increase in dues last year. We are encouraged by this growth, but we must find ways to increase interest in our organization. All active physicians should be supporting the ideals and programs of organized medicine.

Another fine accomplishment of KSMA is the activation of the Insurance Review Board, approved at the last meeting of the House of Delegates. This Board has a great potential of service in assisting the insureds, physicians, and insurance companies in areas of disagreement.

The KSMA Committee on Medical Discipline has, after two years of study, come up with a recommendation for the formation of a Judicial Council. We urge you to study this proposal, which you will be asked to pass on, carefully. It is most important in the life of our profession.

A new area of service was entered this year when KSMA sponsored the first Conference on Mental Health. This was a very successful meeting and should become more productive in the future.

We have had a very good year in the 1964 Kentucky Legislature. The functioning of the Kentucky Legislative Key-Man System was increasingly effective. We are told there is still room for progress. We were delighted to see the Board of Trustees pass a special resolution commending our legislative leaders for their good work.

At the time this report is written the fate of the Administration's efforts to pass compulsory medical

care for the aged through social security, which passed the Senate, is yet to be determined. Representatives of your state society have journeyed to Washington on three different occasions in this connection during the year, including KSMA's Annual Dinner honoring its senators and congressmen. To all those who have worked so diligently to keep our senators and congressmen informed on this issue so vital to the public welfare, we want to express our deepest appreciation.

We could go on and on. However, before we turn to other matters, we would like to acknowledge the work of our Committee on Disaster Medical Care and the Highway Safety Committee for their efforts in working with state governmental agencies in developing programs in the public interest.

Your President has had a busy year, too. We have left the state to attend seven meetings on behalf of KSMA. During the year we have given approximately 20 speeches, 14 of which were before KSMA Trustee districts. We have attended four meetings of the KSMA Board of Trustees, six meetings of the Executive Committee, and more than a dozen other KSMA committee meetings and meetings of other types sponsored by KSMA.

This year, that you have given me the honor of serving as your President, climaxes 15 years of serving in the ranks of your Associaton. During this time we have seen KSMA mature and become an active and influential force in many areas of endeavor in our state. You have consistently placed people in responsible positions that are knowledgeable and that have provided you with good leadership.

This is most fortunate for us all. Whether we like it or not, our responsiblities as physicians and as a medical organization have been projected into fields never before recognized by medicine as obligations. We must keep our position of leadership in health matters not only in the area of treating the sick, but as they relate to political and socio-economic developments.

To help maintan and extend our leadership and influence, I would like to make for your consideration the following recommendations:

1. That all county medical societies schedule at least one meeting a year for the purpose of communicating to its members developments in medical organization work of such interest to them. We urge the use of the following sources—KSMA officers, AMA delegates or alternates, and members of the KSMA Headquarters Staff to assist you.

*2. A growing movement in the Area Hospital Planning. This has a great potential for public service, if appropriately guided and kept on a voluntary basis. We must resist all efforts to make it a compulsory movement. We specifically recommend KSMA participation at every opportunity.

3. There have been many recent developments in Third Party Medicine. Good medical care must be provided to our people. Prevention of exploitation of both the public and the profession is our responsibility. We urgently recommend that KSMA use its best and most experienced talents in this area.

Note: This item was referred to Reference Committee No. 2.

4. Obviously, we must be looking for young physicians who are willing and able to be trained to assume positions of responsibility in KSMA. Moreover, we must not overload experienced men who can and do accept responsibility in KSMA. We will urge, therefore, that the Board of Trustees, the appointing authority, limit the appointment of each member to one position as a matter of general policy. There are a very few limited cases where this is not in the best interest of KSMA. The Board will judge these.

5. Medicine is a jealous mistress. This does not excuse us from cooperating more closely and enjoying the best of relations with the allied professions. We specifically recommend that the Board of Trustees provide the leadership in the appropriate committees to explore ways wherein there can be more cooperation with, and greater assistance to, our allied professions.

6. Articulate and aggressive minorities, often well financed and with smart leadership, are becoming more effective in influencing health legislation not in the public interest. The need for the selection and election of congressmen and senators inbued with the principles of the American Free Enterprise System is more compelling than ever. We urge your continued support of and membership in the Kentucky Educational Medical Political Action Committee.

*7. Our Hospital Committee and each individual doctor must take time to inform the many new and old hospital trustees throughout the state of their responsibilities, question them on what kind of job they think they are doing, and do they feel generally satisfied with their policy formulation in their boards. Subjects to talk on are: (1) trustee orientation, (2) trustee education, (3) board/medical-staff relationship, (4) hospital-personnel relationship, (5) public relations, (6) community relations.

Note: This item was referred to Reference Committee No. 2.

May I make an urgent plea now for you as delegates from our 120 county medical societies—the very backbone of medical organization in Kentucky—to return to your county societies and faithfully and fully report the work and actions of this House of Delegates. You have, indeed, a great opportunity.

The many splendid accomplishments this year are the product of what we might call "KSMA team effort." So first, I would like to express my deep appreciation to the official family of KSMA—this includes the vice presidents, other officers, officials of the House and the Board of Trustees and the Councils and Committees—for their superb efforts. In this we would like to include the leadership of KEMPAC. We are very proud of the work that has been done.

And, of course, behind the scenes in all of this is our Headquarters Staff. Without it, little if any of what has taken place would have been accomplished. I am grateful to each member of the staff for his support.

George P. Archer, M.D., President
Kentucky State Medical Association

Recommendations, Reference Committee No. 1

The Report of the President, with the exceptions of numbered paragraph 2, page 3 and numbered paragraph 7, page 4 was reviewed and is a summary of the activities of the President with suggestions for future action by the Society. The Committee recommends approval and acceptance of this report.

We also wish to commend our President for a job well done and express our appreciation for his efforts.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of President, Woman's Auxiliary to KSMA

This year Kentucky reached two milestones: a phenomenal growth in membership to 1,516 and a visit with each county auxiliary by the state president or president-elect, usually by both. Our trips enabled us to call on potential members-at-large to "sell" Auxiliary. This visiting combined with the un-

ceasing efforts of the membership committee, other interested members, and the county auxiliaries added 151 more members than we had last year.

We encouraged active participation by members-at-large. Ten such members were on the state board as president-elect, councilors, and committee chairmen. Others taught baby-sitting, worked on health careers, made Johnny coats (hospital gowns from men's discarded shirts), participated in legislative activity, and assisted with membership. In several instances auxiliaries invited members-at-large from surrounding counties to their meetings, demonstrating the friendliness we found everywhere.

Emphasis remained on tailoring the program to fit the auxiliary's interests and its community's needs. Four issues of "Blue Grass News" carried information from state officers and chairmen and reports from county presidents. As individuals, doctors' wives touched every facet of community activity; as organizations, the auxiliaries participated in varying degrees in programs suggested by National. The summation of achievements in this report does not reflect the enormous contribution of service by individuals.

Intensive information was disseminated about AMA-ERF and various methods for securing contributions and raising money, paving the way for future increased use of such techniques.

Interest in civil defense resulted in donations to a local rescue squad, programs for self-education, representation at meetings, and offers of service. One auxiliary sponsored a civil defense first-aid course for members of Health Career clubs and one for itself. (Since 1960 that county's chairman has taught eight classes in civil defense for civic organizations.)

Broad-based and kaleidoscopic, community service projects truly reflected local interests and community needs: health education and fund-raising drives, immunization programs, diabetes detection, audiometric testing, cancer research, glaucoma screening, blood banks, blood mobiles, youth fitness, and medical quackery. Auxiliaries gave volunteer service or other aid to hospitals, a home for the aged, a penal institution, schools for the handicapped and retarded, flood relief, Girl Scouts, and underprivileged children. One group volunteered its services to an industrial commission seeking to attract new industry to the area by offering to entertain wives of visiting industrialists and acquaint them with local assets.

Nine auxiliaries have loan or scholarship funds for health careers. The state auxiliary currently has two students using its loan fund. Efforts to interest students in health careers were made through career clubs, career days, films, speakers, literature, sponsorship of candy-striper programs, training of practical nurses, and teas and tours for students of nursing. One auxiliary helped furnish a rooming-house provided rent-free by a group of doctors to medical students with financial need, while another helped furnish a lounge at a school of nursing. The state chairman compiled information about health career scholarships and loans available in Kentucky and sent it to each high school in the state.

Participation in international health activities increased. Fourteen auxiliaries donated one or more of the following: sample drugs, bandages, thermometers, surgical scissors, medical books, and Johnny coats. One group extended international hospitality by inviting wives of foreign doctors in its community to be "social members" and another continued last year's interest in families of foreign doctors in its midst.

Each auxiliary and member-at-large were urged to offer assistance for "Operation Hometown." One auxiliary had three letter-writing coffees. It also encouraged people to hear Doctor Annis when he spoke in the area. At each meeting, many groups had reports on pending legislation, although only three had programs on the subject. One group assisted in every way with the passage of a county health tax.

Eight auxiliaries had programs on mental health, three showing "A Cry for Help." One provided clerical assistance at a monthly mental health clinic, while others donated money, clothing, toilet articles, and toys to mental health institutions or projects. (Profits from a style show netted over a thousand dollars for mental health!) Two auxiliaries sponsored students at a state facility for mentally retarded, providing gifts, spending money, letters, and visits.

Special efforts were made for proper usage of seat belts by members of the state and local boards. A survey indicates that 56% use them all the time, 30% use them only on trips, while 14% still do not have them. A physician discussant showed the film "Broken Glass" at Fall Conference. Three counties sponsored GEMS projects (baby-sitting courses).

The By-laws Committee has worked seriously and thoughtfully making editorial changes in the Constitution and By-laws for purposes of clarification and conformity with present practices. Actual changes in meaning or procedures will be presented for action by the Convention, with a proposal that the Constitution and By-laws be reprinted as amended.

For the ninth consecutive year a health citation award will be presented at the Annual Meeting to a lay person or organization for an outstanding contribution in the field of health. Nominations for the award are made by county auxiliaries and members-at-large.

In the words of three county presidents, "We have worked hard, but we have had fun, too"; "We have accomplished the greatest objective of all—improving relations among doctors' families"; and "In general, we have tried to be of service to our communities and a credit to our husbands' profession".

The Auxiliary has been blessed in having a sympathetic parent organization that has understood our problems, shared our hopes, guided our efforts, praised our accomplishments, and contributed to our financial support. Officers, trustees, members, staff —all have consistently helped us with their kindness, their patience and their interest. Their acknowledgement of our efforts made us strive for even greater goals.

Mrs. J. Murray Kinsman, President
Woman's Auxilary to KSMA

Recommendations, Reference Committee No. 1

This report was reviewed by the reference committee and is a resumé of the excellent work by our Woman's Auxiliary. This committee wishes to recommend acceptance of this report and to commend Mrs. Kinsman and her Auxiliary members for a job well done.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the President-Elect

The President-Elect is, upon election, a member of the Executive Committee of the Board of Trustees and a member of the Council on Scientific Assembly. Until one serves on the Council on Scientific Assembly, he has no idea of the work and effort that goes into preparation of the scientific program for an Annual Meeting. These people deserve much credit and get little for bringing together such a fine program as we have had for this year and for the arrangements for meeting in the New Convention Center. The activities of the Executive Committee and the Board of Trustees will be given by the chairman of the Board.

The President-Elect attended two meetings of the National Association of the Blue Shield Plans. Hundreds of great physicians have donated their time and efforts for a good many years for the development of this great movement. Blue Cross and Blue Shield have been our chief weapons with which to

fight Government intervention. They must be protected, improved, and preserved.

The President-Elect served on a special "Committee to Study the Activities of the Appalachian Regional Hospitals, Incorporated." This is mentioned only to call your attention to the importance of reading the report which will be given elsewhere. The very essence of private, competitive medical practice and ethics are involved. Your best will be called upon to decide some of these matters.

Only one speech of importance was made by the President-Elect and that was to a regional group of the "Student Branch of the American Pharmaceutical Association," which was held in Lexington. These people are eager to be friends of the physicians and they will be a source of great assistance when such is needed.

The annual Washington dinner for the Kentucky Senators and Congressmen was attended for the first time. This too will be reported elsewhere, but to the President-Elect, it appeared to be highly successful and well worth the time and expense.

Your President-Elect looks forward to serving the Association as it's President and anticipates hard work, cooperation and success for the coming year.

Delmas M. Clardy, M.D.
President-Elect

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the President Elect, which was a resumé of his activities for the past year and they recommend acceptance of this report and pledge their wholehearted support to Doctor Clardy for the coming year.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Speaker of the House

We wish to urge every Delegate to be aware of his responsibility in helping to shape the future of Kentucky Medicine.

Guide lines for ethical operation of various types of medical services are forged here. Full participation in reference committee discussions is desirable so that mature judgment might prevail before resolutions and recommendations are presented to the House at it's second meeting.

Your Speaker is eager to see a greater degree of unity develop in all of the elements of the medical community. As he carefully reviewed his list of Delegates to KSMA for 1964, he was disturbed to note, as far as he was able to tell, not a single full-time faculty member of a medical school was a Delegate. He would urge counties having medical schools to give this full consideration in 1965.

Remember, DELEGATE, your voice can and should be heard.

Attend Reference Committee Meetings!!

Garnett J. Sweeney, M.D.
Speaker of the House

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Speaker of the House and recommends acceptance with a commendation for a job well done.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Chairman, Board of Trustees

Highlights of the four regular meetings of the Board of Trustees held during the 1963-64 year included delineation of duties of all the committees under the councils, an effort to reduce publication costs of the Journal, the implementation of the orientation course, and action on recommendations in the field of medical licensure, grievances, and third party medicine.

The Executive Committee of the Board of Trustees scheduled six meetings during the associational year. The Executive Committee takes two kinds of actions: (1) makes recommendations to the Board; or (2) acts on behalf of the Board.

You will agree, I am sure, that it would be time consuming to undertake to report all of the actions listed in the 163 pages of minutes covering the Board of Trustees and Executive Committee during the past associational year. The purpose of this report is to cover some of the more important matters. The minutes of these meetings are always available to any member at the Headquarters Office.

I must pay tribute to the members of the Board for their unquestionable loyalty and devotion to the responsibility of their office. The very high percentage of attendance at all meetings conclusively demonstrates the seriousness with which the members view their obligations. It has been a pleasure and an honor to work with such men.

First Meeting—The Board of Trustees held its first and re-organizational meeting Thursday, September 26, at the Phoenix Hotel in Lexington, Doctor Asman serving as temporary chairman.

Doctor Asman recognized the new members of the Board of Trustees and the new Alternate Delegates to the AMA: John Dickinson, M.D., Glasgow, Western Vice-President; Charles G. Bryant, M.D., Louisville, AMA Alternate Delegate; William W. Hall, M.D., Owensboro, AMA Alternate Delegate; and C. C. Rutledge, M.D., Hazard, AMA Alternate Delegate; Rex E. Hayes, M.D., Glasgow, Sixth District Trustee; W. Donald Janney, M.D., Covington, Ninth District Trustee; and Robert E. Pennington, M.D., London, Fifteenth District Trustee.

He then recognized officers and Board members who were returning to serve on the Board the coming year: Delmas M. Clardy, M.D., Hopkinsville, President-Elect; Carlisle Morse, M.D., Louisville, Central Vice-President; Keith P. Smith, M.D., Corbin, Treasurer; J. Thomas Giannini, M.D., Louisville, AMA Delegate; Carl C. Cooper, M.D., Bedford, Eastern Vice-President; Wyatt Norvell, M.D., New Castle, AMA Delegate; Donald Chatham, M.D., Shelbyville, Seventh District Trustee; Douglas E. Scott, M.D., Tenth District Trustee; and Hubert C. Jones, M.D., Berea, Eleventh District Trustee.

Doctor Scott was then elected as chairman for the new Associational year.

Doctor Payne was elected vice-chairman. Doctors Snider and Denham were elected to serve on the Executive Committee.

The Executive Committee, which under the Bylaws serves as the nominating committee with the president-elect acting as chairman, presented its recommendations for council and committee personnel during the coming year. The Board gave these matters full consideration.

The request of the Louisville Chamber of Commerce presented at an earlier meeting, asking that the KSMA change its meeting date either one week before or one week later than originally planned, was considered for final action. It was explained that KSMA was asked to change the date in order that a larger national convention of importance to the community might be brought to Louisville at this time.

A quick investigation was made during the meeting and it was decided that the 1964 Annual Session

of KSMA would be held September 29, 30 and October 1.

Second Meeting—The second meeting of the Board for the 1963-64 associational year was held December 12. KSMA Delegates to the AMA reported on the two resolutions that were introduced by our delegation at the Portland Interim Meeting of the AMA in December. It was explained that while the AMA agreed in principle with both resolutions, that various agencies of the AMA were working on the suggestions covered by the two resolutions.

The report of the Council on Legislative Activities was heard and its recommendation that the Association support the legislative proposal to strengthen the Medical Examiners System was approved.

The Board agreed unanimously to support the request of the University of Louisville for increased appropriation by the 1964 Kentucky Legislature.

The Board voted to resist any legislation designed to change Tuberculosis Hospitals into Chronic Diseases Hospitals.

It was agreed by members of the Board to go along with the State Board of Health in drafting regulations providing for limited licensure for interns and residents on an annual basis.

The Board agreed to make an appropriation in the amount of $7,500 for the coming year to the Kentucky Educational Medical Political Action Committee's Board of Directors for educational purposes, and the Board also appointed directors for KEMPAC for the 1964 calendar year.

Under the recommendations of the Council on Medical Education and Hospitals, the Board voted to have the faculty achievement awards presented each year during the President's Luncheon at the Annual Meeting.

Also, the Board voted on a recommendation of the Council on Medical Education to continue the present appropriation for postgraduate medical education and finally, approval was given for the paying of honoraria to the Senior Day speakers.

Appreciation was officially expressed to Eugene Conner, M.D., the editor of the special Sixtieth Anniversary Issue of The Journal. It was indicated that twenty-three of the twenty-eight Board Room Chairs have been contributed by members.

Third Meeting—The Board of Trustees held its third regular meeting of the year at Jenny Wiley State Park Wednesday, April 22. Following the approval of the President's Report and Headquarters Office Report, the recommendations of the Advisory Committee to the Editor were considered.

These included reducing the number of scientific pages to nineteen, alternating certain departments, deletion of the Washington Page and other suggestions designed to reduce the cost of publishing the Journal.

A recommendation from the Council on Scientific Assembly to increase from $50 to $100 the honoraria paid guest speakers was not accepted.

A resolution expressing appreciation to the President, the Chairman and Co-Chairman of the Council on Legislative Activities, Mitchel B. Denham, M.D., Mr. Bobbie Grogan and all KSMA Key Men at all levels for the excellent work done during the Legislature was unanimously passed.

Eugene Conner, M.D., professor and chairman of the Department of Anesthesiology at the University of Louisville was elected the official historian of KSMA to succeed the late Emmet F. Horine, M.D.

The Board unanimously went on record endorsing the candidacy of Robert C. Long, M.D., Louisville, to succeed himself as a member of the AMA Board of Trustees when the Annual Meeting of the AMA is held in San Francisco in June.

As a matter of properly recognizing the Woman's Auxiliary to KSMA, the Board of Trustees adopted a resolution authorizing the operation of the Auxiliary as an adjunct of the Association.

Consideration was given to Resolution B submitted by the Campbell-Kenton County Medical Society to the 1963 KSMA House of Delegates. The House accepted the reference committee report sending the resolution to the KSMA Board of Trustees for its final disposition. After full discussion, the Board voted to return the resolution to the Campbell-Kenton County Society with the statement that "The Board is in sympathy with the inherent intent of the resolution," but felt it would not be able to specifically implement it.

Following consideration of the grievances, which involved a number of the districts, the Board turned its attention to the reports of the Councils.

The House of Delegates had authorized each of the six KSMA Councils to delineate the duties of the committees under each council and make recommendations to the Board of Trustees.

The Board voted that as these recommendations of the Councils were approved, they would become the policy of the Association covering the broad duties of the committees. General duties of each Council are set forth in the Bylaws.

The Board accepted the recommendation from the Council on Communications and Public Service that KSMA be permitted to endorse commercial advertising under the auspices of the association or county medical society concerning public service programs in medicine such as emergency calls, house call problems, dealing in good taste with factual medical problems. The Mandatory Indoctrination Program, approved by the 1963 House of Delegates, had been referred to this Council for recommendations as to implementation. These were read and approved by the Board.

The Board passed a motion requesting the Committee on Public Health to investigate encroachments by the State Department of Health on the private practice of medicine and report back at the next meeting of the Board. The recommendation was accepted that an organization of physicians interested in the medical aspects of sports be set up.

The following recommendation from the Advisory Committee of U of K, was accepted, among others:

> "The primary function of the University Hospital is education. It is designed for the instruction of students and to facilitate the continuing postgraduate education of the practicing physician as well as the advancement of scientific knowledge through research. Regrettably, the University Hospital, therefore, must differ from a community hospital. Though offering to care for as many patients as it is able, it cannot, in justice to its fundamental objective, accept all patients who present for admission."

The Board approved the budget as presented by Doctor Dixie Snider, Chairman of the Budget Committee. And in that short sentence as in others in this report, there are covered many, many hours of thoughtful work.

The Board voted to ask the State Board of Health to make available to the association more information on new programs it was undertaking, except in emergencies.

The Board adjourned after being in session eight hours and forty-five minutes at 5:45 p.m.

Fourth Meeting—The fourth regular meeting of the Board of Trustees was held Wednesday evening, August 5 and all day Thursday, August 6 in the Board Room at the Headquarters Office.

The President's report covering his varied activities since the April 22 meeting of the Board was complimented by the chairman and unanimously accepted.

Sam A. Overstreet, M.D., and Walter S. Coe, M.D., were unanimously elected for another two-year term as editor and associate editor respectively of The Journal of KSMA.

At this meeting of the Board each year the reports of all councils, and standing committees that are to be submitted to the House of Delegates are reviewed.

Recommendations to the House of Delegates on these reports will be found at the conclusion of each report in the House of Delegates envelopes.

The Board voted to make a one-quarter page ad in the special Courier-Journal supplement, which will be published Sunday, January 17, 1965 commemorating the centennial of the University of Kentucky.

A recommendation of the Executive Committee cited the extremely heavy workload of the three male members of the KSMA Headquarters Staff and after probing various remedies, recommended that a fourth man be added to the Headquarters Staff. After full discussion, the Board voted to implement the Executive Committee recommendation. The Executive Secretary was authorized to re-arrange office space in this connection.

Following the approval by the House of Delegates of *Resolution L* from Muhlenberg County stating that the interest of patients are best served under conditions of free choice of physician and of hospital, and of fee for service, the Board of Trustees appointed a committee to investigate medical practices in those areas of Eastern and Western Kentucky where methods of practice were noticeably in question in these respects. The committee made its report at the August meeting of the Board of Trustees. The report with its recommendations has been referred to the Judicial Council of the AMA for clarification of ethical points in the situations reported and in the implementation of the committee's recommendations. The reply from the Judicial Council is being awaited.

You will recall that a year ago you approved the recommendations of your Board of Trustees to the Appalachian Regional Hospital, Inc. The recommendations were three: that practice in the hospitals be on a fee for service basis; that there be free choice of physician; and that there be no doctor's offices in the hospitals. While it cannot be said that any of these things have been yet fully accomplished, all of them must eventually be, if more doctors such as the area needs are to go there without handicap.

The Board of Trustees appointed a committee to meet with the director of these hospitals to discuss and keep informed on medical practice in the area and in the hospitals. The committee has met on three occasions during the year, twice with Karl Klicka, M.D., President of ARHI, and practitioners in the area. James Holloway, M.D., chairman of our Hospital Committee, and a member of this special committee of the Board of Trustees, has made several trips to the regional hospital area, met with the local hospital advisory councils and physicians in attempting to help with some of the problems involved.

It would have been a sad day for Kentucky if these hospitals would have become empty shells. Their re-establishment has been a magnificent undertaking of the Presbyterian Church and deserves all the support we can properly give it.

The special committee appointed by the Board of Trustees consisted of the President of the Association, the President Elect, the Chairman of the Hospital Committee, and the Chairman of the Board of Trustees. This committee feels strongly the value and importance of the three recommendations made originally by the Board of Trustees. These appear basic to any other advice or help we can give these hospitals.

We are becoming aware of the difficulties in establishing new fundamentals such as these for institutions where they had never existed. The difficulties are complex and present variations in different hospital areas. They cannot be overcome suddenly or at once everywhere. ARHI, however, is to be commended by us on the considerable accomplishments of its first year. And on this we can hope for a future of fine institutions in areas that will be attractive to physicians.

The rate of such further development we believe will be in proportion to the application of our stated recommendations: Freedom of choice of physician; fee for service, and no doctor's offices in these hospitals.

The Chairman of the Board called on the six trustee district grievance committee chairmen to give reports on matters pending in their districts.

Other actions of the Board included approval of a suggestion that an appropriate committee of the KSMA meet with a like committee of the Kentucky State Association of Registered Nurses to plan an agenda for a joint meeting with representatives of the two groups later in the fall; to ask the Office of Dependents Medical Care to print a new fee schedule covering the true medicare program in Kentucky; heard a report on proposed IRS efforts to tax income from advertisements in scientific journals and voted special commendation to Harold McPheeters, M.D., the retiring Commissioner of Mental Health.

In closing this report, the chairman would like to express his appreciation to all the members of the Board and those who have met with the Board for their contributions in expediting the Association's business.

Douglas E. Scott, M.D.
Chairman

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Chairman of the Board of Trustees, which is a resume, of the actions taken by the Board of Trustees during the year and it also was noted by this committee that the Board of Trustees has been extremely active and has spent many long hours carrying out the actions of this organization.

This committee recommends acceptance of this report with commendation to Doctor Scott and members of the Board of Trustees for their devotion to the responsibilities of their offices.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Secretary

One year ago the Secretary's Report consisted, in part, of the philosophic reflections of Woody Troutman after seventeen years of devoted and dedicated service to the Association in this office. His words, and his works, have been a source of inspiration to me.

This report will relate some of the impressions gleaned from this, the first year of the three-year term to which you elected me last September. The job of Secretary of the Association is not an arduous one. It does consume a certain amount of time away from one's practice for meetings of the Board of Trustees, the Executive Committee of the Board, the annual and interim meetings, and certain committees and councils.

There are frequent conferences, personal and by telephone, with the Executive Secretary, and occasional decisions to be made to expedite the affairs of the Association if the President and Chairman of the Board are not immediately available. The vast volume of the work, however, and the countless minutiae are handled by our very capable Executive Secretary and his administrative staff.

What, then, are these impressions? I am impressed by the seriousness with which the elected officials of the Association accept the responsibilities of their offices; with the readiness with which these men travel from all parts of the state, at no expense to the Association, for Board meetings to implement the dictates of this House, to establish policies between meetings of the House, and to conduct the ordinary business of the Association. As an example of this devotion to duty, I would mention the almost 100% attendance at a two-day meeting of the Board of Trustees on August 5 and 6, when the Board was in session for twelve and one-half hours.

I admire the accomplishments of our Delegates and Alternate Delegates to the AMA who work so faithfully to represent the members of this Association and the people of Kentucky; and the many mem-

bers of KSMA Councils and Committees who, one might say, do the "grass-roots" work of fulfilling many of the functions and purposes of our Association; and, lastly, this House of Delegates, the legislative body of the Association, for the seriousness and astuteness of its deliberations in setting the policies of our organization.

I am impressed by the tremendous volume of work performed by our Executive Secretary, his Assistants and the personnel of the Headquarters Office. Few of us realize that there are more than sixty Boards, Councils and Committees functioning within the frame-work of the Association. The Executive Secretary and his assistants must "staff" each meeting of each of these groups: working with the chairman in planning the meeting, preparing the agenda, providing background material, keeping the minutes and preparing the permanent digest of the proceedings, implementing the instructions and directions of the committee, and representing the committee at other meetings.

Contemplate for one moment the amount of work and time, the amount of administrative "know-how" that is evident in the organization and smooth working of this annual meeting. In one period of three months the administrative staff worked and/or attended 26 association Council and committee meetings, 22 other meetings of association groups and various health-related organizations, and three out-of-state meetings on the national level.

Bear in mind that these councils and committees have been created by us, the association and cooperation with other health-related groups have been dictated by this House, by the Board of Trustees, or by the facts of life in the 1960's, and the Administrative staff is doing *our* work in fulfilling the purposes for which KSMA was organized and which justifies its continued existence.

Turning over the coin, I have been impressed in a negative sort of way by a relatively few members of the Association, including some members of this House, who consistently criticize the officials of the Association, condemn its activities, and complain about its dues. This attitude would appear to be due either to a failure of communication between the officials and the members, or to apathy on the part of the member. The latter explanation is favored since every member has the opportunity to learn and understand the workings of his Association—if he is willing to take the time and make the effort.

All meetings of this House, of the Board of Trustees, and of all Councils and Committees are open to every member in good standing. The Journal, the Communicator and other publications of the Association are mailed to every member. There is every opportunity to be informed on—and to be active in—the affairs of the Association.

As your Secretary, I believe you are being conscientiously represented, your money is being well spent, and your Association is a worthy "face" of organized medicine in Kentucky in 1964.

Henry B. Asman, M.D.
Secretary

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Secretary to the House of Delegates with its remarks and recommends acceptance of this report with commendation to Doctor Asman for a job well done.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Editor

The past year has been marked by no unusual changes in the Journal. Continuity of policy and detail has been effected by weekly meetings of the managing editor, J. P. Sanford, with the Editors and by fairly frequent contact with the chairman of the Advisory Committee to the Editor, George Brockman, M.D. The Council commissioned the advisory committee to make a study of the financial affairs of the Journal. This was done in a very efficient manner by Doctor Brockman and his committee in a meeting held at Headquarters on January 16, 1964. The policies suggested at that time have been implemented so far as is practical.

There have been twelve monthly Editions of the Journal. On October of 1963 Beverly Towery, M.D., did the symposium issue featuring Endocrinology. In November of 1963 Eugene Conner, M.D., edited the 60th anniversary issue which apparently was well received by the subscribers. In January of 1964 William Rumage, M.D., edited the Disaster Care Issue presenting before the readers many neglected features of disaster care which have been promoted by the American Medical Association.

Curtailment of scientific matter in the Journal has been necessary because of the limited revenues from advertising. It is well known that there has been a significant decrease in drug advertising in general. During the past three years the Kentucky Medical Journal has perhaps felt the impact less severely than have other state journals of our class. It has, however, been necessary to delete certain monthly features and publish others on a three-month-basis in order to keep a satisfactory balance between scientific and advertising matter. Mr. Sanford believes that there are prospects for substantial improvement in this respect during the present year and next.

It should be pointed out that no subscription fee for the Journal is taken from the Kentucky State Membership dues each year. If a subscription fee of $5.00 or $10.00 every year were channeled into the Journal as is done in some states, we would be able to present a better financial picture than we are able to under the present plan. We and the Editors' Advisory Committee do not particularly recommend that any such change be effected; it would be only taking money out of one pocket and putting it into the other. We merely wish to point to this as the principal explanation of the Journal's financial deficit.

At the July meeting of the Board of Trustees Doctor Coe and I were reelected to our respective offices for a term of two years. We wish to express our gratitude to the trustees for this expression of confidence which we shall endeavor to justify.

Sam A. Overstreet, M.D.
Editor

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Editor of the Journal of KSMA and wish to commend Doctor Overstreet for a job well done in maintaining the excellence of our Journal under difficult circumstances and recommends acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Treasurer* **

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Treasurer, which is a well prepared report of our financial status and wish to commend Doctor Smith. We recommend acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

(Note: Any member wishing to see a copy of the Treasurer's Report may do so by writing the KMA Headquarters Office, 3532 Janet Avenue, Louisville, Kentucky 40205.)

**Please see Organization Section, page 1018, for graph showing distribution of KMA funds.

Report of the Delegates to the American Medical Association

Your Delegates had a successful year as your KSMA representatives to the AMA House of Delegates. The Clinical Session of the AMA met in Portland, Oregon, December 1 to 4, 1963 and the 113th Annual Session met in San Francisco, California, June 21 to 25, 1964.

The clinical session at Portland was to have been the last meeting in which J. Vernon Pace, M.D., Paducah would have served as a delegate from KSMA. However, Doctor Pace decided to "step-aside" and allow John Quertermous, M.D., Murray, Kentucky, the AMA Alternate Delegate from the Western section of Kentucky, to be seated as delegate rather than serving as alternate at the Portland meeting. Doctor Pace should be praised for this by the entire KSMA and your senior delegate from Kentucky called the attention of the AMA House of Delegates to this unselfishness of Doctor Pace.

Tobacco and health, human rights, physician-hospital relations, continuing medical education, the cost of medical care and federal subsidization of prepayment plans and health insurance companies were among the major subjects acted upon by the AMA House of Delegates at both the Portland and San Francisco meetings.

The House of Delegates recommended that the AMA Board of Trustees use the talents of Edward R. Annis, M.D. and other qualified spokesmen for medicine with appropriate remuneration.

Norman A. Welch, M.D., Boston, Mass., was inaugurated as AMA President, Donovan F. Ward, M.D., Dubuque, Iowa was named President-Elect of the AMA. Carlton Wertz, M.D., Buffalo, New York, was named Vice President. Milford Rouse, M.D. of Dallas and Walter C. Bornemeier, M.D. of Chicago was named Speaker and Vice-Speaker of the House respectively.

There were two members of the Board of Trustees of the AMA standing for re-election—R. R. Robins, M.D. of Camden, Arkansas, and our own Robert C. Long, M.D. of Louisville, Kentucky. Alvin J. Ingram, M.D. of Memphis, Tennessee opposed Doctor Robbins and was elected in a very close vote. Doctor Long had no opposition and was re-elected for a three-year term to the Board of Trustees. The extreme high level of respect for Doctor Long is attested to by the absence of any opposition to his membership on the Board of Trustees. Doctor Long was also appointed to membership on the AMA-ERF Board of Directors.

The speaker of our own House of Delegates, Garnett J. Sweeney, M.D. of Liberty, suggested to the Board of Trustees of KSMA that the delegates and alternate delegates to the AMA be in attendance at the Reference Committee meetings. The delegation will serve as reference sources for the reference committee deliberations. Your delegates and their alternates will attend the same reference committees it was their responsibility to attend at the AMA sessions.

George P. Archer, M.D., our KSMA President has repeatedly recommended and urged the component medical societies of KSMA to use their delegation to the AMA House of Delegates for programs. Especially as sources of information as to AMA attitudes, positions, decisions, etc., which at times is misunderstood misconstrued, misinterpreted because of lack of communication.

Your delegation is available to fulfill your invitations.

Your AMA Delegation would be remiss if they did not express their appreciation for the help given them by Deans Smith and Willard, Doctors M. R. Cronen, David Cox, Carl Cooper, George Brockman, Murray Kinsman and many other Kentucky physicians. To our wives, our appreciation and thanks for a job well done in the Kentucky Hospitality Room. And last, but definitely not the least in important work, our Executive Secretary Joe Sanford and his assistant, Bob Cox, our thanks.

Wyatt Norvell, M.D.
Senior Delegate to the AMA

Recommendations, Reference Committee No. 1

The committee reviewed the Report of the Delegates to the AMA which is a resumé of their activities during the year, and especially, at the AMA convention. We wish to commend all of our delegates and alternate delegates, and especially, to commend Doctor Robert C. Long for his excellent representation of the KSMA and we recommend acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Executive Secretary

If you were to count all of the committees, councils, the House of Delegates on the KSMA organizational chart and add a few ad hoc committees that have been named for special tasks, you would see that there are more than 65 different groups operating within the KSMA during this Associational year. In one way or another, the work of each of these groups —together with the officers of the Association—will be manifested in the reports to this House or in the functioning of this House. In the background you will find your staff carrying out your directions.

Consider for a moment the magnitude of effort involved by all of the committees, councils, and different KSMA groups in determining the contents of your envelope. Beginning in May meetings are scheduled—having sometimes as many as two and three in one day—as the various groups put together their reports. Sometimes, there are problems in arranging meetings, fighting vacation schedules and lack of understanding of the problem. After this is determined, the Headquarters Office has the responsibility of assembling this material, meeting the deadlines, cutting the stencils, proofing, and assembling the 250 copies of each report. This adds up to a total of nearly 225 pages in your envelope.

The work of the committees, Councils, Board of Trustees, and officers as reported in your envelope involves a substantial portion of the time and effort of your staff during the year. It is the responsibility of the staff to arrange for meetings, work with the chairmen on preparing the agenda and arranging background material, attend the meetings, write the digest of proceedings, implement policies, write a digest of the committee's meeting for the Journal, and assist in the preparation of these reports.

On the basis of a 40-hour week, I spend 4½ weeks attending 44 KSMA committee meetings, other medical and related meetings numbering 53 for a total of 97 meetings. Mr. Cox worked 55 KSMA committee meetings for a total of 182 hours. The staff as a whole spent 706 hours (17 weeks) attending 243 KSMA sponsored or related meetings. In a limited number of instances, it was necessary for more than one staff member to be present.

Let's consider what goes into staffing the meetings of the Board of Trustees. This twenty-eight member Board met six times during the past Associational year and was in session slightly more than 35 hours. The Executive Committee of the Board also held six sessions spending approximately 18 hours. A considerable amount of time was spent by the staff in preparing and distributing material to each member of the Board in order to assist the Board in carrying out your work with greater efficiency in the minimum amount of time. Minutes of these meetings cover more than twenty-five pages.

Another year-round activity of the staff is the preparation for this Annual Meeting. You might be

interested in the procedure of working with the 14 specialty groups—the general scientific sessions. Because of the time limit, let's consider only one—that of preparing for the technical exhibits display.

The technical exhibits hall provides the member with a vast wealth of information, adds color to the meeting, and makes it possible for us to have one of the best small state meetings in the country without cost to you. In the preparation for this exhibit, we will write more than 300 letters to the 75 exhibitors which will contribute this year nearly 10% of our total income.

As your committees and councils seek to serve the public and the profession, new programs involving a greater amount of staff time are developed. A case in point is the recently re-activated Mental Health Committee-sponsored First Conference on Mental Health in May. Many staff hours were involved in promoting the Congress, working with allied and other organizations, meeting arrangements, numerous mailings to individuals and groups, working with the chairman and members of the committee, and making arrangments for speakers.

One of the most important activities of the Headquarters Office concerns working in the legislative area both state and national. In this field the necessity for quick and sometimes extended activities often comes in the midst of other highly important staff responsibilitiies which frustrates the orderly accomplishment of business. This year, the legislators met in Frankfort and our Director of Field Services was on the scene both day and night practically every day the legislature met.

As emergencies arise in Washington, your staff must be equipped and in a position to momentarily dispense information through the KSMA Key Man System in order that you may be appropriately informed to make such decisions and take such actions as are necessary.

Another KSMA public service program which is rendering an increasingly important service to the public is the Placement Service and Rural Kentucky Medical Scholarship Fund. We are now averaging about one call a day by the placement service. This time-consuming program includes helping both representatives of communities wanting physicians and physicians wanting other physicians to assist them and physicians looking for places to locate.

The carrying on of the house-keeping activities of the Scholarship Fund is an absorbing task for the Director of Field Services and involves almost 50% of the time of his secretary.

Another note-worthy accomplishment during the year involving considerable staff time was the implementing of the 1963 House of Delegates action calling for the delineation of the duties of all KSMA committees. Following approval of the recommendations to the Board of Trustees, this information has been compiled in a 15-page report. From now on, when a committee is appointed each member will receive a copy of the statement of the duties of the committee. This information will also be available to officers and other members who may wish to have it.

It is not feasible to undertake the reporting of all staff activities. Perhaps your attention should be called to the major programs, however, that involve a great amount of time. These include the Interim Meeting, the Rural Health Conference, the great amount of follow-through involved in the work of the Highway Safety Committee and the Disaster Medical Care Committee with State Governmental Agencies, and the Diabetes Education and Detection Drive (which is one of our most popular public service programs).

Coordinating the material that goes into the Journal of KSMA ordinarily means the collection and preparation for publicition of the scientific material in the Journal which is a considerable task in itself. The KSMA Communicator is prepared by the staff under the direction of our secretary and numerous news releases covering the KSMA programs are distributed throughout the year.

As the services of the Association to the profession and public increase, so does the number of telephone calls. I will average from 12 to 20 incoming calls a day and from 10 to 15 outgoing calls. Other members of the Executive staff run about the same. During legislative emergencies, the phone-call load may double or triple.

We hope in highlighting a few of the activities of our staff here will give you some indication of the volume of work that is carried on each year in your behalf. You are more than welcome to visit our Headquarters and personally inspect your Association's operation.

All of the members of the Headquarters staff join me in expressing our full appreciation for the kindness, consideration, and cooperation shown us and the fine direction given to us during the Associational year by the President, the Chairman of the Board, the Speaker of the house, the Secretary and the Treasurer, the Editor of the Journal and all of the Council and Committee Chairmen and members.

To the other members of the Headquarters Staff, I want to express my unlimited gratitude for the dedication and efficiency you have demonstrated in taking care of the largest volume of work that the staff has yet been asked to handle in any one year. It is a pleasure to work with all of you, and I'm most thankful for your loyalty to KSMA.

J. P. Sanford
Executive Secretary

Recommendations, Reference Committee No. 1

The Report of the Executive Secretary was reviewed which is a resume of the services performed by Mr. Sanford and his Headquarters Staff. We wish to take this opportunity to thank and commend Mr. Sanford and his entire Headquarters Staff for their usual excellence in performance of their duties.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the McDowell Home Committee (Paragraph 3, page 4)

It is a matter of pride that the Association should continue to maintain this National and World Shrine in a proper manner. The financial contribution of the Kentucky State Medical Association is obviously necessary, and it is logical to increase this contribution from $3,000 to $4,000 per annum.

The following is the financial report as prepared by the financial office of the Kentucky State Medical Association.

STATEMENT OF INCOME AND EXPENSE— McDOWELL FUND FISCAL YEAR, JULY 1, 1963—JUNE 30, 1964

	ACTUAL	BUDGET	
		Budget Allowance	Over or (under) Actual
McDowell Home:			
Income:			
Kentucky State Medical Association Appropriation	$3,000.00	$3,000.00	$ —
Kentucky Surgical Society Contribution	1,000.00	1,000.00	—
Admissions, Sale of Cords and Books	1,399.11	1,000.00	(399.11)
Miscellaneous Donations	655.00	750.00	95.00
Total Income	6,054.11	5,750.00	(304.11)

Expenses:			
Repairs to Home	1,919.19	500.00	(1,419.19)
Salary - Hostess	1,429.00	1,380.00	(49.00)
Insurance	525.69	500.00	(25.69)
Supplies	113.77	200.00	86.23
Telephone	203.23	200.00	(3.23)
Publicity	707.36	300.00	(407.36)
Payroll Taxes	82.60	80.00	(2.60)
Gas and Electricity	631.96	500.00	(131.96)
Miscellaneous Services, etc.	1,166.53	800.00	(366.53)
Sales Tax	40.40	50.00	9.60
Total Expenses	6,819.73	4,510.00	(2,309.73)
Excess Expense Over Income	$ (765.62)	1,240.00	$ (2,005.62)
ACTUAL UNDER BUDGET		(2,005.62)	
		$ (765.62)	

Recommendations, Reference Committee No. 1

This committee reviewed paragraph 3, page 4 of the Report of the McDowell Home Committee which deals with the necessity to increase the financial contribution of the KSMA to the McDowell Home Fund from $3000 to $4000 per annum. This committee, in reviewing its treasurer's report, notes this increase is necessary for the continued operation of this National and World Shrine in a proper manner, and recommends acceptance and implementation of this recommendation.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Resolution E

Campbell-Kenton County Medical Society

WHEREAS, we are all deeply impressed by the ability of Dr. E. Annis, M.D., to stand before any type of audience and present the case for "American" Medicine as we know and desire it and

WHEREAS, we feel that his services are so valuable that his ability should be used by the American Medical Association permanently in the fight against socialized medicine and

WHEREAS, it is our opinion that he has brought more favorable publicity for the American Medical Association and the American Doctor than any other single representative of American medicine, therefore be it

RESOLVED,

That Dr. E. Annis, M.D., be urged to accept lifetime employment by the American Medical Association as Representative of American Medicine to the people of the United States, at a salary commensurate with his earning capacity in private practice.

Recommendations, Reference Committee No. 1

Resolution E introduced by the Campbell-Kenton County Medical Society, which recommends that Doctor E. Annis, M.D., be urged to accept lifetime employment by the American Medical Association as Representative of American Medicine to the people of the United States, at a salary commensurate with his earning capacity in private practice was reviewed by this committee and we recommend acceptance of this resolution.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Mr. Speaker, I move the adoption of the report of Reference Committee No. 1 as a whole. (Motion was seconded and carried.)

REFERENCE COMMITTEE NO. 1
Ballard W. Cassady, M.D., Pikeville, Chairman
T. R. Bryant, Jr., M.D., Lexington
Walter L. Cawood, M.D., Ashland
Mary Pauline Fox, M.D., Hazard
Robert T. Longshore, M.D., Covington
Paul J. Ross, M.D., Louisville

REFERENCE COMMITTEE NO. 2 †

W. Gerald Edds, M.D., Chairman

Reports on Scientific Assembly and Medical Education

† *See note (†) bottom of column one, page 962.*

Reference Committee No. 2 considered the following reports:

11. Report of the Council on Scientific Assembly

12. Report of the Council on Medical Education and Hospitals

Resolution C — Straight Internships vs. Rotating Internships

Resolution D—Private Hospital Internships

1. Report of the President

Report of the Council on Scientific Assembly

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alterations or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . ."

The material is this report of the Council on Scientific Assembly is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * *

Results of the 1963 KSMA Annual Meeting were carefully reviewed by the Council when it held its meeting on October 16. Members of the Council felt that the 1963 meeting held in Lexington went very well indeed in view of the physicial and other limitations that figured prominently in its development. It was reported that the specialty group scientific programs were quite well attended.

The Council then turned its attention to the 1964 Annual Meeting. Inasmuch as this annual session was to be held in the new Convention Center, It was necessary for the council members to do an on-the-spot inspection and organize the facilities in what it hopes will serve the best interest of all concerned.

The Council was pleased to learn that the Smith Kline and French people would again sponsor a Trans-Atlantic CPC. It was decided that again Wednesday afternoon would be set aside for as many specialty groups as possible to meet, and with other specialty groups holding their meetings simultaneously

where there is no conflict in subject matter. The cooperation of our fifteen specialty groups is greatly appreciated.

Since the past two meetings had experimented with the "symposuim in depth" approach to scientific programming, it was decided to relax this policy somewhat, and permit more individual presentations.

Your Council members feel perhaps that the average KSMA member is not aware of the tremendous amount of committee work involved in the planning, development and presentation of an annual meeting the size of our meeting. Your Council would point out that because our Committees take their obligations so seriously and plan so effectively, we have one of the best small state meetings in the nation. The members of our Council wish to express their deepest appreciation to all who have contributed to the success of this meeting.

The following reports of the committees serving under the Council are herewith submitted.

Recommendations, Reference Committee No. 2

Reference Committee No. 2 met and considered the report of the Council on Scientific Assembly. Your Reference Committee is well pleased with the efforts of the Council and wishes to commend it and also the committees under the Council on the excellent work that it has done.

Scientific Exhibits Committee, Benjamin B. Jackson, M.D., Louisville, Chairman

The KSMA Scientific Exhibits Committee met on July 15 to review applications and select exhibitors for the 1964 KSMA Annual Meeting.

The Committee is appreciative of the continuing interest in Scientific Exhibits. Eighteen exhibits were approved for the meeting. All exhibits are to be in place by 8:00 a.m., Tuesday, September 29 and are not to be removed until 3:30 p.m., Thursday, October 1.

A special committee will judge the exhibits on Tuesday morning and select the first, second and third place winners. A plaque will be presented to the first place winner during the Scientific Session, Wednesday morning, September 30. A certificate of appreciation signed by the KSMA President and Chairman of the Board of Trustees, will be given to each exhibitor as in the past.

Recommendations, Reference Committee No. 2

The Scientific Exhibits Committee report was reviewed and it was noted that there are 18 carefully selected exhibits. Your Reference Committee feels that this committee should be applauded.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Scientific Program Committee—Douglas M. Haynes, M.D., Louisville, Chairman.

Your committee held two meetings during the year and your chairman attended several other meetings with different groups while putting together the plans for the 1964 KSMA Annual Meeting Scientific Program.

Members of your committee met with representatives of the fifteen cooperating specialty groups to make plans and coordinate their participation in the scientific programming for this session. This committee wishes to express its appreciation to all the cooperating specialty groups for the splendid contribution they make to our overall scientific program.

As pointed out in the report of the Council, policy for the format of the general session scientific programs was changed this year, permitting more individual presentations. Your committee, however, is pleased to report that guest speakers were cooperative in following the committee's wishes in the scientific areas the committee wished covered.

Much preparatory effort has gone into the plans for the Trans-Atlantic telephone conference that will be presented Tuesday afternoon at 2:00 p.m. This should be a most worthwhile and practical presentation.

Our committee was asked to consider and is glad to approve the suggestion that the period of 7:00 a.m. to 8:30 a.m. be set aside Wednesday morning for meetings of the various medical-religious group programs. We understand the KSMA Committee on Medicine and Religion is coordinating this matter.

The deep and most sincere gratitude of the members of our committee is extended to all of our guest speakers, the specialty group presidents, the hardworking participants in the Trans-Atlantic Telephone Conference and its sponsor, the Smith Kline and French Laboratories, and to all who are participating in the two symposia on Thursday.

Recommendations, Reference Committee No. 2

Your Reference Committee reviewed the report of the Scientific Program Committee and wishes to commend Doctor Douglas Haynes and the members of his committee for the great amount of work and the way it is put together. We would also like to thank the Smith, Kline and French Laboratories for sponsoring the Trans-Atlantic Conference.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Technical Exhibits Committee, Clyde T. Moore, M.D., Louisville, Chairman

Your committee on technical exhibits is experimenting with two innovations for our 1964 Annual Meeting. The first is a message center that is located at the center of the hall and is designed to be of maximum service to the members in receiving their messages. The center will be presented and staffed by the Southern Bell Telephone Company.

A second experiment relates to the use of the so-called "three-sided booth". Purpose of the "three-sided booth" is to offer more privacy to the member as he seeks information on questions of interest to him and to the exhibitor as he makes his presentation. This is the first experiment of this sort in a medical convention. You are urged to go into each of these booths in order that you may see how it operates and give your reaction to either those who operate the booth, or to our KSMA Headquarters Staff.

This year we have reached an all-time high in space sales for a total of 75, the revenue from which will just about cover the increased cost to the Association of holding the Annual Meeting at the newly renovated, air-conditioned facilities of the Convention Center.

Your committee feels the technical exhibit hall makes many fine contributions to our meeting. To those of you who are officers and delegates—we urge you to visit the exhibits for the information you require and also to express appreciation for the exhibitor's patronage of our meeting.

Recommendations, Reference Committee No. 2

The report of the Technical Exhibits Committee pointed out that we had the largest number of Technical Exhibits in our history. The Committee is fully aware of the amount of work involved in this program and understands that we had the largest number of booths in the history of our Association.

Mr. Speaker, Reference Committee No. 2 recommends the adoption of this report with our appreciation. (Motion was seconded and carried.)

Golf Committee, Kenton D. Leatherman, M.D., Louisville, Chairman

The Golf Committee met on May 28 and finalized the plans for the 1964 KSMGA Golf Tournament which will be held Monday, September 28 at the Big Springs Country Club in Louisville.

In past years the Golf Tournament has been held

over a four-day period during the KSMA Annual Meeting. This created a number of problems including conflicts with the Scientific Sessions. This committee recommended last year that one day be set aside for the Golf Tournament and other recreational purposes at which time there would be no conflict with the Scientific Sessions. This recommendation was approved by the 1963 House of Delegates and the Council on Scientific Assembly has set aside Monday, September 28 as the day for the 1964 Tournament. All participants in the Tournament must play on that day.

Since the Big Springs Country Club will be closed to everyone except the doctors on that day, it is imperative that all participants be pre-registered so that proper arrangements can be made for food, etc. In order to participate in the 1964 Tournament, the Golf Committee will accept only those applications received by September 1, 1964. Publicity and other aspects of the Tournament will be the same as in the past.

COUNCIL ON SCIENTIFIC ASSEMBLY
Harvey Chenault, M.D., Lexington
Douglas M. Haynes, M.D., Louisville
Benjamin B. Jackson, M.D., Louisville
Clyde T. Moore, M.D., Fern Creek
Edmund D. Pellegrino, M.D., Lexington
Delmas M. Clardy, M.D., Hopkinsville, Vice Chairman
George P. Archer, M.D., Prestonsburg, Chairman

Recommendations, Reference Committee No. 2

It was with satisfaction that the Reference Committee noted that the Golf Committee's Tournament was held in one day and was not in competition with the Scientific Session. Your Reference Committee recommends that this practice be continued.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Reports of the Council on Medical Education and Hospitals

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

". . . . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . . ."

The material in this report of the Council on Medical Education and Hospitals is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Medical Education and Hospitals has met three times during the associational year, November 14, 1963, February 20 and June 4, 1964. At its first meeting the Council discussed the activities of its various committees and approved a statement outlining the duties of each committee. The Committees serving under the Council are: Advisory Committee to the University of Kentucky, Advisory Committee to the University of Louisville, AMA-ERF Committee, General Practice Committee and Hospital Committee.

During this past year, the operation of the postgraduate medical education fund was turned over to the Council. We have continued our activities in the field of postgraduate education by maintaining a calendar of all scheduled meetings and serving as a clearing house, and maintaining the publication of the "Continuing Educational Opportunities" page in the KSMA Journal.

At its second meeting, the Council discussed a number of the programs being conducted by the committees serving under the council. Procedures for selecting the 1964 recipients of the KSMA Scientific Achievement Award were outlined and these recipients (one from each of Kentucky's two medical schools) were selected at the Council's third meeting. This Council has been asked to make a study on "Town and Gown" relationships and we developed a questionnaire on Medical Education which we feel will prove useful in studying and improving "Town and Gown" relations. This questionnaire was sent to all Kentucky physicians during June. It is not anticipated that the results of the questionnaire will be tabulated and evaluated in sufficient time to present a report during the 1964 KSMA Annual Meeting.

The members of the Council on Medical Education and Hospitals, believing it would be an added service to the physicians of our state, recommend to the KSMA Board of Trustees that the Board encourage the State Board of Health to include the speciality of each individual physician in future printings of the Kentucky Medical Directory.

The report of the committees covering their activities and recommendations follows:

Advisory Committee to the University of Kentucky, Andrew M. Moore, M.D., Lexington, Chairman

The Advisory Committee to the University of Kentucky met separately and in a joint session with the Advisory Committee to the University of Louisville on February 6, 1964. The committee members reviewed the 1963 report to the House of Delegates of the Council on Medical Education and Hospitals, and made further recommendations as appropriate to this committee.

As a means of making the purposes of the university hospital known and understood by both physicians and the public, the committee approved a statement concerning the university hospital. This statement was also approved by the Advisory Committee to the University of Louisville, the Council on Medical Education and Hospitals, the Board of Trustees, and disseminated to all Kentucky Physicians.

The KSMA Executive Committee requested the Advisory Committee to the University of Kentucky to make a recommendation pertaining to dues for full-time faculty and teaching members. The following recommendation was made in a joint meeting with the Advisory Committee to the University of Louisville.

It is recommended that this motion be submitted to the Constitution and Bylaws Committee through the Board of Trustees with the action taken by the Board of Trustees for action by the 1964 House of Delegates. "The KSMA Advisory Committees to the University of Louisville School of Medicine and the University of Kentucky Medical Center, having studied the dues problem as referred to them by the Executive Committee at its October 31 meeting, recommend that the dues for full-time teaching and research members be fifty percent of the dues for regular active members."

COUNCIL ACTION: The Council on Medical Education and Hospitals accepts the report of

the Advisory Committee to the University of Kentucky. It is noted by the Council that the Board of Trustees, at their April 22 meeting, did not adopt the recommendations of this Committee pertaining to dues.

Recommendations, Reference Committee No. 2

Reference Committee No. 2 approved the report of the Advisory Committee of the University of Kentucky.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Advisory Committee to the University of Louisville, George A. Sehlinger, M.D., Louisville, Chairman

The Advisory Committee to the University of Louisville met once during this associational year on February 6, 1964, and also held a joint meeting with the Advisory Committee to the University of Kentucky on the same day.

At the request of the KSMA Board of Trustees, the committee prepared a statement of the committee's duties, which subsequently was approved by the Council on Medical Education and Hospitals and the Board of Trustees. A number of recommendations made by the Council last year were reviewed and the committee felt the recommendations were being implemented and no further action was taken.

In the joint meeting with the Advisory Committee to the University of Kentucky, a statement concerning the university hospital was approved. This same statement was later approved by the Council on Medical Education and Hospitals and the Board of Trustees, and has been disseminated to the physicians in Kentucky.

The KSMA Executive Committee requested the Advisory Committee to the University of Louisville to make a recommendation pertaining to dues for full-time faculty and teaching members. The following recommendation was made in a joint meeting with the Advisory Committee to the University of Kentucky.

It is recommended that this motion be submitted to the Constitution and Bylaws Committee through the Board of Trustees with the action taken by the Board of Trustees for action by the 1964 House of Delegates. "The KSMA Advisory Committee to the University of Louisville School of Medicine and the University of Kentucky Medical Center, having studied the dues problem as referred to them by the Executive Committee at its October 31 meeting, recommend that the dues for full-time teaching and research members be fifty percent of the dues for regular active members."

COUNCIL ACTION: The Council on Medical Education and Hospitals accepts the report of the Advisory Committee to the University of Louisville. It is noted by the Council that the Board of Trustees, at their April 22 meeting, did not adopt the recommendations of this Committee pertaining to dues.

Recommendations, Reference Committee No. 2

The Reference Committee considered the Report of the Advisory Committee to the University of Louisville by Doctor Sehlinger and approved this report and concurs with the action of the Board of Trustees that the dues of both the members of the faculties of the University of Louisville and the University of Kentucky should be the same as physicians in private practice.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

AMA-ERF Committee, Walter I. Hume, Jr., M.D., Louisville, Chairman

The AMA-ERF Committee did not have a meeting this year. The programs of the American Medical Association Education and Research Foundation have been promoted periodically throughout the year by means of the KSMA Journal and the Communicator. The Committee also had an exhibit at the 1963 KSMA Annual Meeting, and the physicians of Kentucky received additional promotional material on a quarterly basis from the AMA.

Allocations of the 1963 AMA-ERF contributions to Kentucky's two medical schools were presented by check at the 1964 KSMA Interim Meeting to the Deans of the medical schools. The University of Kentucky Medical Center received $5,279.28 and the University of Louisville School of Medicine received $10,369.36. In addition to funds for medical schools, another major project of AMA-ERF is the loan program for medical students, interns and residents. This program made 142 loans to Kentuckians during 1963, compared to 99 loans made during 1962, for a total of $282,100.

The Committee is pleased to have this opportunity to express their appreciation to the physicians of Kentucky and the Woman's Auxiliary for their support of the AMA-ERF.

Recommendations, Reference Committee No. 2

The Reference Committee considered the report of the AMA-ERF Committee by Walter I. Hume, M.D. and noted with pride the contributions to the University of Kentucky Medical Center of $5279.28 and to the University of Louisville School of Medicine in the amount of $10,369.36.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

General Practice Committee, Homer B. Martin, M.D., Louisville, Chairman

Since the work of the entire year was reviewed at the May 7, 1964, meeting of the Committee held in Louisville, our report will cover this one meeting. Interest in general practice affairs by each individual was shown by the perfect attendance. A representative of each medical school kindly attended and contributed to the meeting discussions.

I. Resolution M—Actions by Our Medical Schools.

Resolution M was submitted to the House of Delegates last year by the Laurel County delegates. In essence, this resolution called the attention of our medical schools to the attrition in the numbers of general practitioners and asked what specific actions were being planned to offset and reverse this trend. This committee was assigned this resolution.

Dr. Charles F. Blankenship, Chairman of the Department of Community Medicine, University of Louisville School of Medicine, stated that the general practice lectures were considered worthwhile and would be continued. A more desirable time is being sought so that all students can benefit from them. He expressed the interest of the school in programs being developed at the University of Kentucky and elsewhere.

Dr. Nicholas J. Pisacano, Director of Postgraduate Education at the University of Kentucky College of Medicine, then discussed the exploratory efforts of the school to formulate a three-year program which would provide adequate training in family practice. To this end, a meeting was held in Lexington during March of this year which brought together the nation's leading authorities in this field. Despite the enthusiasm of the Kentucky faculty, progress must be deliberate and the present goal is tangible progress rather than publicity about the program which is still in the planning stage. After Dr. Pisacano's discussion, members of the General Practice Committee made specific suggestions and criticisms of the course of study being organized.

Dr. Seeley then moved that the committee report to the Board of Trustees that both state schools are evincing satisfactory progress in formulating programs as sought by Resolution M and we recommend the House of Delegates express their willingness to each school to assist these proposed and current programs in any way possible while stressing the

urgency and desirability of such programs. The motion was passed unanimously.

II. Questionnaire Comparing General Practice and Specialty Practice.

To gain understanding of the reasons why diminishing numbers of medical graduates enter general practice with a proportionate increase in specialty ranks, the committee early this year prepared a mail questionnaire. This was to be sent to each Kentucky physician who was known to have done both general and specialty practice. Eighty forms were sent out and 52 replies were received.

The physicians responding represented 16 different specialties. They had started their specialty practice at an average age of 35. Their average age is now 46. Their replies were based on a collective total of 267 years in general practice. In the decision to enter specialty practice, these factors were rated in importance as follows:

Table 1: Factors in Decision to Specialize

	Per Cent Rating the Importance As		
	Major	Some	None
Personal Satisfaction from Work	48	23	29
Feelings of Inadequacy	44	34	22
Family Time	40	42	8
Formal Postgraduate Time	41	38	21
Recreation Time	19	58	23
Time to Study at Home	28	48	24
The Work Load	24	50	26
Lack of Intellectual Challenge	27	34	39
Inadequate Cultural Facilities	34	20	46
Inadequate Physician Contact	26	35	39
Income Received	0	43	57
Status as General Practitioner	12	30	54
Lack of Hospital Privileges	16	23	61
Personal Health Factors	9	26	65

As to how these items were affected by specialty practice, a comparison is offered below. It is striking that *none* of the factors is considered worse in specialty practice.

Table 2: Changes Effected by Specialty Practice

	Per Cent Rating Factors		
	Improved	Unchanged	Worse
Feelings of Adequacy	69	31	0
Time for Postgraduate Courses	76	22	2
Time to Study at Home	67	31	2
Contact with Fellow Physicians	66	32	2
Cultural Facilities	65	33	2
Intellectual Challenge of Practice	76	20	4
Personal Satisfaction from Work	74	20	6
Family Time	69	25	6
Recreation Time	62	32	6
Status	54	40	6
Work Load	56	34	10
Income	55	31	14
Hospital Privileges	45	51	4
Personal Health Factors	27	67	6

As to whether general practice was a help in residency, 73% replied a great deal, 27% moderately, and 0% none at all. As to whether general practice was a help in practice, 78% answered it helped a great deal, 22% felt moderately, and 0% thought it of no benefit. Eighty-one per cent of those polled would recommend all graduates do some general practice to gain experience, but 9% thought this nonessential. As to present attitudes toward general practice, 61% considered it an integral component of American Medicine without reservation, but 35% stated substantial improvement necessary.

Opinions were requested as to how the number of general practitioners could be increased. Space does not permit the separate listing of the 27 different ideas. The principal ideas were increased general practitioner participation in medical schools, increasing the postgraduate training period, teaching the value of the general practitioner in our medical schools and encouraging general practice before specialty training.

It is hoped that these results will delineate those elements of specialty practice which make it more desirable. By creating programs for training competent family physicians stressing these positive factors, the shift toward specialty training may be brought to an end.

III. Recommendations for Work of Next Year's Committee

Citing the deteriorations of health care which must accompany the decline of general practitioners and a concomitant rise in cultists, the general practice committee should continue its active interest and participation in the Kentucky Programs. The University of Kentucky program as planned is a national leader. To further elucidate the problem, it would be of great advantage to ascertain more accurately the number and availability of general practitioners in each community of the state.

The chairman wishes to exercise his prerogative to express his sincere thanks for the efforts and labors expended by an excellent committee.

Recommendations, Reference Committee No. 2

The Reference Committee considered the report of the General Practice Committee with Doctor Homer B. Martin as chairman and approved the report with the suggestion that in addition that private hospital internships be encouraged in order to increase the number of physicians in general practice.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Hospital Committee, James B. Holloway, M.D., Lexington, Chairman

The Hospital Committee met twice in this last year, once in October of 1963 and again in May of 1964. In addition to that there have been a number of "Dry Run" Committee meetings, "Dry Runs" at hospitals, and several trips by the Chairman of the Committee to Eastern Kentucky regarding the Appalachian Regional Hospital situation. Items to be discussed are:

1. The accomplishment of the Kentucky State Medical Association Staff and the Kentucky Hospital Association in getting up a manual for "Dry Run" Groups consisting of two parts. (a) A part sent to the hospital preparing for a "Dry Run". (b) A part to the "Dry Run" members. This has been an accomplishment by our technical staff and by the Kentucky Hospital Association and is to be commended. The book will be invaluable in coming years for those who are on the "Dry Run" Committees for the first time.

There was one "Dry Run" in Western Kentucky, another at Columbia, Kentucky and lastly one at Cardinal Hill in Lexington, Kentucky. The "Dry Run" at Columbia, Kentucky resulted in the Committee advising the hospital not to, at the present time, apply for accreditations since they were not ready. This has saved some embarrassment on the part of the hospital and the community as I feel sure they wouldn't have made the grade. The "Dry Run" at Cardinal Hill in Lexington has not been done at the time of writing. The details of the "Dry Run" in Western Kentucky are not available to me as it was done by the group from Paducah.

2. The Committee has perused with interest the AFL-CIO Policy Statement on Hospitals and agrees with the platitudes vouchised therein but we most emphatically disagree with their attitudes of interfering in the management of the running of hospitals.

AN AFL-CIO POLICY STATEMENT ON HOSPITALS

I. The Growing Importance of Hospitals

Hospitals have become agencies of vast importance to the American people, including the 45,000,000 men, women and children who are members or in the families of members of the AFL-CIO. Many of our grandparents regarded hospitals as places only for the poor, places to which people rarely went except with the expectation to die. Now we all consider hospitals as centers of healing, in which most of our babies will be born and in which we can obtain the ever-advancing benefits of scientific medicine, made possible by the technical facilities, the trained personnel and the careful organization of all these, assembled in the hospital.

While much essential medical service is rendered in doctors' offices, in clinics and in patients' homes, nevertheless the hospital is more and more becoming the center for the advancement of medical science and the application of its powers for the benefit of human beings.

The remarkable development of hospitals* has taken place since the beginning of the present century. In the last fifty years, the number of hospitals in the United States has grown 50%, but the number of hospital beds has increased over 400%, twice the rate of the growth in population. The growth has been in quality as well as in quantity. The hospitals of today are vastly more effective in diagnosing and treating disease than they were a half-century ago. They cost more, but private and public expenditures have risen to the challenge. The private initiative and public spirit of physicians and laymen; the devoted unpaid services of many men and women, and the advancing policies of local, state and national governments have brought about this noteworthy advance via the availability and effectiveness of hospital care.

Along with the immense benefits to the people from this progress, certain disadvantages have appeared. It is important to understand and to remedy these disadvantages so far as possible. The professional men and women who provide services in hospitals, the twenty million Americans who use hospitals annually and the 185 million who may use them are all deeply concerned that these remedies be found and applied. No one has a greater concern with the accessibility of hospital care and with the high quality of that care, than the people whose health and lives are at stake, or at any time may be at stake, as patients in hospitals.

Professionals who provide services and those who administer hospitals may declare that patients who receive care cannot usually judge its quality. Organized groups of consumers (Potential Patients) can however, directly or through qualified staffs, appraise many of the elements of quality. The attitudes of patients, their reactions to hospital conditions and services, and their sense of satisfaction or dissatisfaction are highly important. There is widespread feeling that hospital service has become so highly specialized and the personal care of the patient divided among so many different people, that many patients experience no sense of receiving attention as persons; a situation not fully compensated for even by alert attention to the disease.

Let us, therefore, with full appreciation of the skill of our professionals, proceed to state the disadvantages which our experience as patients and potential patients find in hospitals today, and then present our suggestions for remedy.

II. Present Problems and Difficulties

First: The Large and Progressive Increase in Hospital Costs. We appreciate that the benefits of modern medicine cannot be obtained without vastly more elaborate and expensive equipment than formerly, and without a larger number of highly trained professional and technical personnel. Many valuable services which were formerly unknown must now be performed in hospitals. The vast benefits of surgery are possible only through hospitals. Nevertheless, the rise in costs of hospital care has not only been at a greater rate than any other important item in the American family budget, but also at a higher rate than the increase in incomes of a large part of our population.

Second: Hospital Growth Without Community Planning. We are concerned about the large number of hospitals that have grown up in many cities and their suburbs, a few governmental, most non-profit, some profit making; established each for itself, usually enlarging each for itself, without any general plan that would relate the number and locations of hospital beds to what expert opinion judges the area needs or is in future estimate to need. Hospital facilities and services are now too expensive to grow unplanned.

Third: Too Many Small Hospitals, which cannot provide the quality or the range of specialist services which some patients require, and which, either in large cities or in small communities, do not have relations with larger institutions for cooperation in the diagnosis and treatment of such patients.

Fourth: Despite the large and costly increase in hospitals for acute short-term illness, there are *serious deficiencies in facilities* for other great and growing needs; especially: for chronic illness; for patients who can be adequately served in a nursing home rather than in the more costly hospital; for organized plans for care in the patient's home.

Fifth: Insufficient Use of the Diagnostic and Treatment Facilities of the Hospital for Ambulatory Patients, that is, those who can come and go on their own feet for medical attention, without the expensive stay in a hospital bed. The policies of most voluntary non-profit hospitals differ sharply as between bed and ambulatory patients. These hospitals generally accept all economic groups, from the wealthy to the destitute as bed patients; whereas ambulatory patients are usually accepted in the "outpatient department" only when they cannot afford to pay a physician. A majority of these hospitals have no organized provision for ambulatory patients except in an "emergency room."

Sixth: Lack of Assurance to the Patient of Quality of Hospital Care. Quality of care is promoted by the voluntary system of hospital inspection and accreditation, maintained by national professional organizations. Notwithstanding, only about 60% of our 5,500 general hospitals are accredited. Most of the larger hospitals meet the standards and are accredited; only a fraction of the small hospitals are. Few patients are made aware whether a hospital to which they are referred is accredited or not.

Seventh: Deficiencies of our Hospital and Medical Insurance. We have all benefitted by the growth of "health insurance," and we are all indebted to the professional and lay groups which have pushed health insurance plans forward. We are, however, more and more aware of the limitations of most present health insurance plans. These limitations appear from both the medical and the economic points of view.

Medically: Although over 125 million persons are "reached" by some form of health insurance, only a small fraction of these obtain from it a broad scope of curative and preventive services. Economically: Hospitalization insurance, taking non-profit and commercial types together, covers only a little more than half of our total hospital bills; insurance for the services of physicians and surgeons, a much smaller proportion.

About fifty million Americans—mostly among the aged, the rural people and the low-income but self-supporting families in the cities—have no health insurance at all. Thus many who especially need it do not get it.

This statement refers to the general hospitals and does not include the very large group of specialized hospitals for mental illness.

The majority of existing health insurance plans are open to abuses which add to costs; they are not organized so as to control or promote quality of care; and they make no provision for preventive services.

Eighth: Insufficient Development of Group Medical Practice. We believe that the vast majority of Americans desire to have the full benefits of modern medicine—diagnostic, curative, preventive and rehabilitative. We are confident that most of the American people would prefer to pay for these benefits on the insurance principle, so that they can put all or most of their expenses into a regular family budget; instead of having to meet unpredictable and often burdensome costs, as is common when fees must be paid for each service. The experience of a number of insurance plans in this country, serving now a total of over four million persons, has demonstrated that when physicians are organized in well-balanced groups and utilize facilities and auxiliary personnel under unified administration, the patient can obtain relatively comprehensive care with the maximum economy. He will have the medical advantage of continuous contact with a personal physician as well as with specialists, and the financial advantage of systematic pre-payment.

Therefore, we desire to see prepaid group medical practice encouraged by voluntary and legislative action. Present obstacles to its development should be removed, especially (1) laws in some states which restrict group practice, and (2) acts by some hospitals and medical societies which restrict hospital privileges for physicians who join group practice units.

Ninth: Lack of Participation of Those Who Use and Pay for Hospital Care in shaping the social and financial policies of hospitals. The same may be said of Blue Cross plans. There are some hospitals and some Blue Cross plans which demonstrate the advantages of such participation. Yet in the main, hospitals and Blue Cross plans are run from the approach of the providers of service. A better balance between consumers and providers is desirable.

Tenth: A Low-wage Policy affecting more than a half-million nurses and non-professional employees is prevalent in many hospitals. The right of the employees of non-profit hospitals to organize for collective bargaining is not protected by Federal law, as it is for workers in industry. Only a few states provide such protection through state laws.

Eleventh: Some Hospitals Discriminate against the admission of patients or in the facilities provided patients, *because of race or color;* and for the same reason, against the admission of certain physicians to the privileges of their medical staffs.

Twelfth: Failure to Utilize the Powers of Government Constructively to deal with some important problems, specified on pages 9, 10 and 11. American hospitals and American medical practice are predominantly non-governmental. We do not propose a governmental system. We do perceive—and mention later—problems which have not been dealt with successfully by voluntary action, and which we do not believe can be.

III. Recommendations for Community Action

Viewing these matters, the AFL-CIO Executive Council has concluded that organized labor throughout this country should give vigorous attention to the improvement of our hospitals in their effectiveness and their economy. We have therefore prepared the following statement of policies and proposals. It is our hope that these policies and proposals will be implemented in practical ways, by other public-spirited agencies.

A. *PLANNING.* No hospital should be built, enlarged or re-located except in accord with a systematic plan of estimated present and future needs for hospitals and allied agencies; a plan prepared by a representative non-profit agency, enlisting the services of impartial experts should be understood to include not only physical facilities, but also services. Every proposal for expansion, brought forward by individual hospitals or others should be evaluated according to the needs defined in the plan—needs not only for beds for acutely ill patients, but also for facilities for long-term patients, for nursing homes, for home care, for ambulatory facilities, for rehabilitative facilities, for facilities for research and education of professional and technical personnel.

Our communities, their surrounding areas and their needs have become so large and complex, and the costs of medical facilities have become so high, that we cannot afford the inefficiencies and the costs of unbridled individual autonomy. Persons and institutions have an obligation to discipline their autonomy in terms of their obligations to their community.

In a few states and in a number of localities, planning councils have already been set up by public authority or voluntary action. In every state there is a hospital council to administer grants for construction under the Hill-Burton Act. Obviously any legislative or voluntary action for state and local planning should take existing councils into account: utilizing, combining, or coordinating the agencies already established. It will be advantageous when the state and local health departments can give leadership in planning. State programs providing hospital care for dependent persons through welfare or health departments can aid in making planning effective.

We recommend that in every State there should be a Hospital Planning Council under this or an equivalent title established by voluntary or public action, or by a combination of voluntary and public action. A majority of the governing body of the Council should be made up of carefully selected and interested persons from all important sections of the general public; the other members to be physicians and other professional persons from different branches of the health field. Similar local or regional bodies should be established, as rapidly as practicable, each covering a major community or hospital service area.

We believe that experience has demonstrated that planning bodies for hospitals are ineffective unless they are able to influence substantially the individuals, organizations, and public agencies from which capital funds for hospital development must be obtained. Financial sanctions are often necessary to bring institutions and agencies to comply with the requirements of a community plan.

B. *CONTROL OF COSTS IN RELATION TO PLANNING.* A plan which includes within its scope all the varied institutional and other facilities needed by present medicine for the diagnosis, care and prevention of disease must also take into account the widely varying costs of these facilities, both as to capital investment and as to operation. A community plan will therefore include methods for guidance and where necessary for controls, for two main purposes:

1) Distributing patients to those facilities which will meet their medical needs at the minimum cost consistent with medical effectiveness;

2) Controlling utilization of hospitals so as to minimize use not medically necessary and to encourage as much use as is necessary.

Methods of guiding and controlling hospital utilization have been developed in some institutions. Their application should be made general instead of spotty. Community organization, supported by organized labor, employers and other who pay hospital bills is necessary to accomplish this with the cooperation of physicians and allied professional persons. The largest contribution towards keeping hospital and other medical care costs within bounds, yet meeting good professional standards, will be found by utilizing the most expensive type of facility—the hospital bed for acute short-term cases—only for such patients as need such intensive care and only for so long as they do need such care. More extensive provision and use of other bed facilities and of ambulatory services are necessary also. Such a goal, we believe, can be reached only when informed members of the general

public participate in an organized way with physicians, hospital administrators and other professionals of the health field.

C. *MAINTAINING AND PROMOTING QUALITY OF CARE.* The present voluntary system of standards, inspection and accreditation, under the auspices of the Joint Commission on Accreditation, should be more widely understood by the general public as a guide to individuals in their use of hospitals and should be fully utilized by these agencies which are important sources of funds for the current expenses of hospitals. We recommend:

1) Accreditation ought not to be limited because of small size of hospital. The Joint Commission on Accreditation and State and local Planning Councils may well consider the standards and the regional relations which should be required of small hospitals.

2) The Joint Commission and its sponsoring bodies should distribute widely information about hospital standards, and how they are maintained in terms understandable by the general public; should cooperate with voluntary and public agencies in so doing; and should make readily available in every locality the names of the hospitals on its accredited list.

3) Public funds paid to hospitals for the care of "Welfare Patients" should be paid only to accredited hospitals, except in cases of emergency or when no accredited hospital is within reach. Organized labor and civic bodies should push for the adoption of this requirement by administrative action when possible and should seek State Legislation when necessary.

4) Every effort should be made as public understanding of the importance of accreditation increases—

a) to persuade Blue Cross and other insurance plans both non-profit and commercial to adopt the policy enunciated above, either on a voluntary basis or by action of the State Insurance Commissions, and

b) to persuade labor and management to follow this policy in their collectively bargained health insurance programs.

D. *INSURANCE.* The extensive experience which organized labor has had with voluntary insurance plans of different types leads us to recommend that Unions in negotiating collective bargaining contracts or in arranging for health insurance in other ways, should select or arrange their insurance according to the following priorities:

1) Plans in which physicians' services are provided through group medical practice;

2) *Plans which provide relatively comprehensive services,* from physicians and surgeons as well as from hospitals, as contrasted with plans which provide or pay for only restricted services;

3) *Insurance plans which provide services,* or which assure payment for services, rather than plans which provide cash indemnities only.

E. *CONSUMER REPRESENTATION OF GOVERNING BOARDS.* The power structure of the majority of non-governmental general hospitals centers in its medical staff, mostly physicians who derive an important part of their income from the care of private patients in the hospital. Naturally, they tend to be more concerned with the interests of the expansion of particular hospitals than with community planning for all hospitals and allied institutions of the area. The majority of hospital governing boards, although possessing full legal authority, have not provided sufficient weight for the community interest. Organized labor should be active in an endeavor to supply a better balance in favor of the community. We recommend:

1) Organized labor and other groups interested in community betterment and community planning should seek adequate representation on hospital boards.

2) Blue Cross has from its beginning been managed mainly by those who provide services with insufficient or no representation of the direct interests of the subscribers, who use the services and who pay for them through insurance plans. We believe that such non-profit plans should be managed by boards, the majority of whose members represent the workers and employers who are subscribers, and who have a direct concern with the scope, economy and quality of the services, with a minority of the governing body composed of those who represent the providers of service. Every effort should be made by the workers and employers who have a financial or personal stake in these non-profit plans, to bring about this essential change in their management, proceeding through discussion and negotiation so far as practicable; through legislation if necessary, or through setting up new plans, properly organized.

3) Unions should undertake systematic education of selected members and officers in the problems of hospitals and health insurance plans, in order that there may be a pool of men and women competent to serve effectively as board members.

4) Pooling action by unions: Local unions, with the encouragement and aid of their state and national bodies, should unify their policies and pool their efforts in dealing with hospitals, physicians, Blue Cross, Blue Shield, insurance companies, or with organizations representing these bodies. Rates, benefits, conditions of eligibility, abuses and problems of administration are all subjects in which common policies and the pooling of bargaining power will be of advantage.

F. *COLLECTIVE BARGAINING FOR HOSPITAL EMPLOYEES.* Although the non-professional employees of non-profit hospitals have the right to organize in unions, they do not have (except in a few states) the same legal protection in exercising this right as do employees in industry. We believe that non-professional employees of all hospitals including non-profit hospitals, should have the same legal protection to organize and bargain collectively as do employees in industry, and that if they were met in a spirit of cooperation by hospital management both groups would benefit. We should like to see progress made towards this goal by negotiation. It must be attained by legislation, if necessary.

G. *RACE DISCRIMINATION.* Discrimination against any patients or segregation of patients because of race or color is a blot upon America. This is equally so in the utilization of physicians and in granting staff privileges to physicians. Such discrimination is especially obnoxious when practiced by agencies legally dedicated to community service. The only ground for exclusion of a physician from hospital staff privileges should be lack of professional competence to perform the services required of him in the hospital.

We urge unions in every locality to take steps and to support other agencies in taking steps, to bring an end to such discrimination, by friendly representations, by legal action under existing laws, or by new legislation.

We recommend that the Joint Commission on Accreditation include non-discrimination against patients or physicians in its requirements for accreditation.

We recommend that the Hill-Burton Act be amended so that federal grants under this act be forbidden to any institution practicing discrimination because of race or color.

IV. Recommendations for Legislative Action

A. *CONSTRUCTIVE USE OF GOVERNMENTAL POWERS.* Many of the preceding subjects have included reference to administrative or legislative action by local, state or federal Governments. Voluntary action in past years, sometimes in conjunction with governmental action, has done much to develop our hospitals, to elevate the quality of hospitals and of the work of their staffs; but it has allowed wide divergencies in standards and in levels of performance to grow up and to persist.

In a country with the human and economic resources of the United States, there is no room for second-class standards in dealing with the health of

human beings. There are many problems and deficiencies which we do not believe can be dealt with by voluntary action alone. Voluntary action has rarely been able, for example, to control the establishment and location of hospitals according to rational plans based on area needs and financial economy. It has failed to apply finely established standards of quality to large numbers of hospitals. It has not succeeded in gaining general adoption of uniform minimum standards of hospital accounting and statistics. We believe that carefully considered legislative and administrative action by governments, designed in cooperation with the professions and institutions concerned, is essential to improve conditions at these and other points.

We recommend:

1) The establishment of an organization for planning hospitals and allied facilities at State, regional and community levels, through governmental or voluntary action, or a combination of these.

2) The enactment in every State, of a law requiring all hospitals to make annual reports of their finances and services to a State Body, according to forms provided by that Body; the reports to be publicly available. A few States have such laws now.

Payments to hospitals by governmental bodies, by insurance plans and by other agencies besides individual patients are now a large and sometimes the major part of hospital current income. Since it is generally accepted as reasonable that such payments should be on the basis of cost of care, it becomes of the first importance to be able to determine what the cost is. Uniform financial and service reports are essential to making that determination in a manner that minimizes inaccuracies and disputes and safeguards against setting payments by arbitrary authority. The American Hospital Association has for many years made authoritatively prepared report forms available to all hospitals, but their adoption is far from general. A simple law such as is proposed would be an aid to good management, not an interference with management.

3) Amend the hospital licensing laws which now exist in all states; so as to include provisions for minimum standards of service, organization and records: instead of, as is usual at present, relating chiefly to the safety and fire protection of the physical facilities.

For organization, service and records, the standards of the Joint Commission on Accreditation provide a sound base; but since the technology of the health field is advancing rapidly, details of standards should be left to regulations rather than be frozen into statutes. Each state must determine for itself whether the Health Department or some other agency shall administer the hospital licensing laws. When enacting such laws, care should be taken to obtain appropriation of sufficient funds for adequate inspection and enforcement. The practical problems of inspection and enforcement focus on the unaccredited hospitals; though of course, the law must apply to all.

3a) To provide for small hospitals in isolated communities, the state licensing law should be adapted so as to require standards appropriate to such institutions. The state-wide hospital plan should include provisions that whenever possible, patients who need diagnosis, surgical or other treatment which the small hospital cannot provide, should be admitted or transferred to a hospital which has the facilities and the specialized personnel required.

First-rate hospitals apply to their medical staffs the principle that each physician on the staff is limited to provide only those services which in the judgment of his professional colleagues he is competent to perform. The same principle should be utilized for hospitals as such.

4) Abolish existing laws in many states which prevent or restrict insurance plans which are associated with group medical practice, or are organized under the auspices of the consumers of services. Enact instead, enabling laws safeguarding the right to establish such plans, with due protection for the professional and public interests involved.

There is no justification for depriving Americans of the right to establish insurance plans of their own choosing, subject to general state laws affecting all insurance plans; or their right to make mutually satisfactory arrangements with physicians or groups of physicians, or hospitals, to supply services to the members of such plans.

5) Provide for federal low-cost loans towards the initial costs of building and equipment of non-profit group practice plans.

6) Provide hospitalization and allied insurance for the group in our population which most need it and which now has the least of it—*the aged;* through distributing the costs over the working life of the individual, according to the social security principle which has been so successfully applied to the maintenance of income during old age.

The voluntary plans, both non-profit and commercial, offer various levels of insufficient hospitalization benefits to persons over 65, at costs not less than $100 to $150 per year. Such costs are obviously beyond the means of a group wherein two-thirds have annual incomes of less than $2,000 (including the incomes of married couples), and 30% with incomes of less than $1,000. America cannot tolerate public charity as the only resource available to its people when they grow old and are sick. The social security principle provides a method of financing consistent with self-respect and economy. For that fraction of the aged who have more adequate incomes, voluntary insurance will have excellent opportunity to offer supplementary insurance.

7) Effect, through administrative action by state and local authorities, or by legislation when necessary, the principle that *payments by government agencies to hospitals,* for the care of patients for whom a public agency is responsible, shall be *on the basis of full cost of service, reasonably determined.* At present there is wide divergency from this principle in many localities.

8) Amend the Hill-Burton Act so as to make the following improvements (subject to provisions made in legislation for general state planning councils as suggested previously):

a) Prevent discrimination by race or color, through preventing future use of so-called "Separate but Equal" accommodations for Negro and White groups.

b) Provide that no existing or proposed hospital may receive a Hill-Burton grant unless it meets the requirements of the state-wide plan, and of its community or regional plan.

c) Require that the state hospital councils shall have majority membership representing the public, a minority the providers of service.

V. Putting Recommendations Into Effect

In order to translate the preceding policies and recommendations into action, labor bodies and cooperating public-spirited groups need blueprints as well as goals. Many of the proposals regarding planning agencies, composition of governing bodies, specific provisions of legislation, etc., need to be worked out with expert advice from various sources, and to be flexible enough for adaptation to diverse local conditions. The AFL-CIO must give leadership in moving from ideas to realities.

The Community Services Committees of AFL-CIO State and local labor councils and local unions should endeavor to enlist other public-spirited groups to cooperate in effectuating these proposals concerning hospitals and the associated medical care problems.

The most important area in which advice is needed is the medical area. Advice and guidance from experienced and socially minded physicians are essential

both in reaching sound conclusions of many matters and also in gaining public recognition and support.

We therefore recommend that the AFL-CIO establish a Medical Advisory Committee to give guidance and counsel on these related matters.

This statement was developed by the National Advisory Council to the AFL-CIO Community Services Committee at the suggestion of the Community Services Activities staff and drafted by a Committee of the NAC which included Dr. Michael Davis, Chairman, Dr. Berwyn Mattison, Mr. Philip Bernstein and Mr. Whitney M. Young, Jr.

Adopted by the AFL-CIO Community Service Committee
February 1963
Approved by AFL-CIO Executive Council, Bal Harbor, Florida
February 1963

3. The most pressing and continuous business before the Hospital Committee has been the Appalachian Regional Hospital situation. The most important facet of this is that a Special Committee has been formed to investigate the methods of practice in Eastern Kentucky and this has relieved the Hospital Committee of considerable burden along these lines. No general statements can be made about the hospital situation but I will make a brief report in a paragraph about each.

A. Hazard—There are no doctors practicing in the hospital. The two former Mine Worker employees who remained in Hazard are in private practice and belong to the State Medical Society and the situation in Hazard as far as the Hazard Appalachian Regional Hospital goes is a happy one.

B. Middlesboro—There are still at the present time four doctors practicing within the walls of the Middlesboro Appalachian Regional Hospital. But plans are afoot to build a building on the grounds which will be sold or given a long time lease to a separate corporation. This building will be large enough to house a number of doctors from town as well. As long as these plans don't bog down the situation in Middlesboro should resolve itself.

C. McDowell—A number of doctors are practicing within confines of the hospital. There are no plans to move them at the present. There are no strong movements afoot to do anything about this because of the isolation of McDowell. Time will take care of this one way or another.

D. Harlan—The Daniel Boone Clinic is still practicing within the confines of the hospital. The local physicians have made no strong objection. The Daniel Boone Clinic dominates the Harlan area and belongs to the County Medical Society. They have long term plans to move from the hospital, but the situation as regards to the viability of the Daniel Boone Clinic is so fluid at the present that no plans are under way.

E. Whitesburg—This has been the most complicated problem and the Chairman of the Committee has made two visits to Whitesburg to try to help straighten it out. At the present time there are three physicians practicing within the confines of the hospital. Two are members of the Daniel Boone Clinic and one a member of the Whitesburg Clinic which is controlled by Dr. Musgrave from Jenkins. The two private practicing physicians in town are anxious to get everybody out of the hospital, but an inspection of all available sites revealed there is no satisfactory site in Whitesburg for more than one doctor's office. The Daniel Boone Clinic is moving in either three or four more doctors this summer. Tentative plans are under way, however, for construction of a building near the hospital by private funds. This drive has just gotten under way and is so tentative it is to be still nebulous.

F. Pikeville—Pikeville will pass into the hands of the Appalachian Regional Hospital Groups in July. Only two former members of the Mine Workers Fund are going to stay in Pikeville. They are moving out of the hospital, but temporarily into a building on the grounds. However, plans are afoot to construct a large building to house all the Pikeville doctors and they are going to go into this building. So I am hopeful that things will do well.

G. South Williamson—Don't know much about this situation. A group practice is being planned and they are going to stay in the hospital. They are orientated to West Virginia although residents of Kentucky.

Council on Medical Education and Hospitals
Walter S. Coe, M.D., Louisville, Chairman
James B. Holloway, M.D., Lexington
Walter I. Hume, Jr., M.D., Louisville
George A. Sehlinger, M.D., Louisville
Donn L. Smith, M.D., Louisville
William R. Willard, M.D., Lexington

Recommendations, Reference Committee No. 2

The Reference Committee considered the report of the Hospital Committee by Doctor James B. Holloway and approved this report in its entirety. Your Reference Committee is aware of the great amount of time expended and personal sacrifices made by Doctor Holloway and wishes to express its appreciation for his splendid leadership.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Resolution C
Jessamine County Medical Society

WHEREAS, many hospitals, especially those associated with teaching institutions, have in recent years instituted in increasing numbers straight internships, and

WHEREAS, such straight internships fail to give the young trainee a well-rounded preparation for the practice of medicine and/or surgery, and

WHEREAS, such straight internships completely fail to provide an opportunity to prepare for general practice, therefore, be it

RESOLVED, that this 1964 House of Delegates go on record as opposing straight internships exclusively* and recommend the institution of well-coordinated, rotating, in-hospital internships of two years' duration, and be it further

RESOLVED, that we instruct our delegates to the American Medical Association House of Delegates to present a similar resolution to that body and to exert all due influence toward the achievement of this goal.

Recommendations, Reference Committee No. 2

The Reference Committee considered Resolution C introduced by the Jessamine County Medical Society concerning Straight Internships vs. Rotating Internships and approved this Resolution as corrected on the floor of the House of Delegates.

Mr. Speaker, I move the adoption of this resolution. (The motion was seconded and carried.)

**The first resolved of this resolution originally read "Resolved, that this 1964 House of Delegates go on record as opposing straight internships per se and recommend . . .". At the first session of the House, the delegates from Jessamine County asked that the word exclusively be substituted for "per se".*

Resolution D
Campbell-Kenton County Medical Society

WHEREAS, the American Medical Association has declared itself in favor of private hospital internships and

WHEREAS, the American Medical Association has also declared itself in favor of individuals entering the general practice of medicine, and

WHEREAS, teaching hospital internships tend to guide students to the specialties instead of General Practice and

WHEREAS, as a result of the action of the Council on Medical Education there has been a reduction in private hospital internships both regionally and nationally, and

WHEREAS, it therefore appears that the Council on Medical Education continuously repudiates the policy of the House of Delegates of the American Medical Association, therefore be it

RESOLVED, The Kentucky Medical Association enlist the aid of the other 49 states to influence the House of Delegates of the American Medical Association to direct the Council on Medical Education to alter its policy to conform to that set forth by the American Medical Association and to encourage private hospital internships.

Recommendations, Reference Committee No. 2

The Reference Committee considered Resolution D which was introduced by the Campbell-Kenton Medical Society on the subject of Private Hospital Internships. While the committee agrees in principle with the Resolution, it would like to recommend the following substitute resolution:

WHEREAS, the American Medical Association has declared itself in favor of private hospital internships and

WHEREAS, the American Medical Association has also declared itself in favor of individuals entering the general practice of medicine, and

WHEREAS, teaching hospital internships tend to guide students to the specialties instead of General Practice and, therefore be it

RESOLVED, The Kentucky Medical Association enlists the aid of the other 49 states to influence the House of Delegates of the American Medical Association to direct its Council on Medical Education to encourage private hospital internships.

* * * * *

Mr. Speaker, I move the adoption and implementation of this substitute resolution. (Motion seconded; carried.)

President's Report
(Paragraph numbered two, page 3)

2. A growing movement in the Area Hospital Planning. This has a great potential for public service, if appropriately guided and kept on a voluntary basis. We must resist all efforts to make it a compulsory movement. We specifically recommend KSMA participation at every opportunity.

Recommendations, Reference Committee No. 2

Paragraph #2, page 3 of the President's Report was reviewed by our Committee. Your Committee wholeheartedly endorses this recommendation and recommends its implementation.

Mr. Speaker, I move the adoption and implementation of this resolution. (Motion was seconded and carried.)

President's Report
(Paragraph numbered 7, page 4)

7. Our Hospital Committee and each individual doctor must take time to inform the many new and old hospital trustees throughout the state of their responsibilities, question them on what kind of job they think they are doing, and do they feel generally satisfied with their policy formulation in their boards. Subjects to talk on are: (1) trustee orientation, (2) trustee education, (3) board/medical-staff relationship, (4) hospital-personnel relationship, (5) public relations, (6) community relations.

Recommendations, Reference Committee No. 2

Your Committee considered this recommendation carefully and feels that it is an excellent recommendation and recommends its approval and implementation.

Mr. Speaker, I move the adoption and implementation of this recommendation. (The motion was seconded and carried.)

Mr. Speaker, I move the adoption of Reference Committee No. 2 as a whole. (The motion was seconded and carried.)

The Chairman of Reference Committee No. 2 would like to express his appreciation for the cooperation of the members of his committee and the views presented by those doctors attending the meeting.

Reference Committee No. 2
W. Gerald Edds, M.D., Calhoun, Chairman
Richard A. Allnutt, M.D., Covington
Walter L. O'Nan, M.D., Henderson
Robert A. Orr, M.D., Mayfield
Samuel D. Weakley, M.D., Louisville

REFERENCE COMMITTEE NO. 3 †

Homer B. Martin, M.D., Chairman
Reports on Legislative Activities

† *See note (†) bottom of column one, page 962.*

Reports considered by this committee were:

13. Council on Legislative Activities Report

15. Report of Council on Communications and Public Service

16. Report of Council on Allied Professions and Related Groups Resolution B

Report of the Council on Legislative Activities

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . .

The material in this report of the Council on Legislative Activities is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
   - *A. National Affairs*
   - *B. State Affairs*
2. *Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * *

NATIONAL AFFAIRS — John C. Quertermous, M.D., Chairman

The Council on Legislative Activities on National Affairs, in submitting this report to the House of Delegates wishes to express its appreciation to the House for the confidence demonstrated in allowing them to serve in this important area in behalf of all the doctors of Kentucky.

The mission of this Council, although becoming more complex and time consuming, is becoming more gratifying because of a significant increase in interest and awareness developing in the individual physician.

The ACTIVITIES of the Council have been productive. We met six times in regular session and one time in Washington, D.C. at the annual Congressional Dinner. There were sixty-one in attendance including eight Congressmen, their wives and staff. Unusual gains were made during this trip, and it is believed that our congressional contacts will be easier in the future because of rapport gained at this meeting.

The Kentucky Chamber of Commerce held a Congressional Dinner in Washington early in April. This was attended by G. L. Simpson, M.D. (a director of the State Chamber), Mr. Joe Sanford, and the Chairman of this Council. This was thought to be productive from the standpoint of cementing relations with this valuable ally, as well as from the Congressmen's standpoint. Mr. Sanford made another series of rounds on Capitol Hill during this trip.

Many physicians were very active in some of the recent primaries and have received grateful acknowledgements from some of the successful Congressional candidates.

Information has been disseminated to the profession through the Legislative Bulletin sent to all Key Men and members of the KSMA Board of Trustees. It is hoped that those receiving the Bulletin will use it to further inform the members of the county societies.

The chief GOAL of this Council is to maintain a situation where the doctor-patient relationship will continue on its present proven successful basis without undue federal government intervention. In order to do this, it is necessary to be continually watchful of bureaucratic attempts to place the financing of medical care of the aging under the Social Security system. It is necessary to keep up our congressional contacts so we will have a voice when our antagonists are successful in bringing a bill to a Congressional Committee or to the floor of one of the houses.

The CURRENT STATUS OF BILLS WITH MEDICAL IMPLICATIONS, with some exceptions, is more reassuring than in the few years past. In the past several months many things have worked in our behalf.

Most important of these is Mr. Wilbur Mills's apparent determination to provide Needed Medical Care at a local level, and outside the Social Security System. He has had important support from Kentucky's Mr. John Watts.

Increases in ordinary social security benefits, with proportionate increases in Social Security taxation, have increased this tax level to nearly ten per cent. This is considered to be the tolerable tax limit for the program at this time. Congressman Mills and his Committee are presently drafting a bill to provide further, and better coordinated, medical benefits along the lines of the Kerr-Mills plan (which Kentucky has shown to be workable). The Council urges every physician to participate in this program because it believes that this plan and its future ramifications will be the weapon we need to forestall frank socialization of medicine.

The Chairman of this Council believes that this planning would not be in process by the House Ways and Means Committee without signal from the President who needs some advertisable change in the current medical financing program in order to show, during his campaign, that he has accomplished a medicare program of his own. This should be done with the help and advice of Organized Medicine.

Every session of Congress is besieged with bills to enlarge the scope of medical care of veterans through the Veterans' Administration. At this writing, there are at least twelve bills pending, and they were recently testified to by David Allman, M.D., and Russell B. Roth, M.D., before the House Subcommittee on Hospitals and the Committee on Veterans' Affairs. The following AMA policy was presented:

1. "The best medical care possible should be provided to veterans who need treatment for conditions incurred or aggravated by their military service."
2. "The best possible medical care should be available to any American."

To enlarge on these premises, the veteran who was injured or became ill in the service of his country, or had this injury or illness aggravated by such service has the RIGHT to necessary medical and hospital care for these service-connected disabilities and he should be permitted to name the hospital of his choice as well as the physician of his choice. The VA should not be able to dictate these matters of vital concern to the veteran. Care of non-service-connected disabilities is not proper concern of the Federal Government.

The Veterans' Bills testified to were HR—170*, 171*, 176*, 229*, 469*, 480*, 2581*, 3681*, 3716*, 4164, 5923*, and HJ Res. 326. The bills with asterisks were the ones taken exception to by the AMA as violating the basic premise as stated above.

HR 7851, HR 8426 and HR 9238 are bills that would exempt from the Anti-Trust laws nonprofit blood banks or physicians who refuse to obtain or accept delivery of human blood or plasma from any other blood bank if the refusal is for the purpose of protecting the health of the recipient of the blood or plasma. The AMA testified in favor of these bills.

On June 4 the House Interstate and Foreign Commerce Committee reported favorably HR 3873, which would permit certain owners of fishing vessels to receive free medical and hospital care at Public Health Service hospitals. AMA opposed. HR 8546 and 29 are identical bills to amend the Public Health Service Act and would provide Federal Student Loans to students of optometry. The AMA and the US Public Health Service opposed these bills.

On May 25 the House passed unanimously the Hill-Burton bill providing future appropriations of 150 million dollars for 1965 and up to 180 million dollars for 1966 and 1967. The FDA moved to bar labeling of oil products as "poly-unsaturated," "low in cholesterol" because such labeling may lead people to believe these foods have treatment value.

The number of bills with implications affecting all phases of medicine is astounding and too numerous to treat effectively here. Any physician desiring information on any of these bills is urged to contact the Council or the KSMA Headquarters, which will direct the request to the proper place.

The Council wishes to commend the Staff of KSMA for an excellence in their work that we believe to be unsurpassed in any medical association in the country. We especially commend the recently resigned Mr. Bobbie Grogan for work he has done in behalf of the Council and for the Association. We are gratified by his expressed willingness to use his skills in our behalf in future legislative sessions. Fred Scroggin, M.D., who has been a uniquely qualified and effective chairman of the Council on the State level as well as an invaluable and knowledgeable member of the Council on National Affairs, will be badly missed. We realize his many duties in this and other associations as a member of national committees and boards are pressing.

We are gratified that immediately following the last legislature the Board of Trustees of KSMA cited Doctor Scroggin and Mr. Grogan and others for the valuable services rendered the Association and the people of Kentucky during the 1964 session of the General Assembly. The Council wishes to endorse and reaffirm this action.

After due consideration, the Council has these RECOMMENDATIONS to make to the HOUSE OF DELEGATES:

1. That the Annual Congressional Dinner be held early in the spring of 1965 at a date to be determined by developments between now and then.
2. That ALL MEMBERS OF THE COUNCIL be reimbursed up to $100.00 for their expenses for the trip to Washington for the dinner.

3. That more direct liaison be established between the Legislative Council and the Board of Trustees (or Executive Committee), especially during legislative sessions in Frankfort.

STATE AFFAIRS—F. R. Scroggin, M.D., Chairman

This is my first report to the House of Delegates as chairman of State Legislative Affairs. Robert Shepard, M.D., on orders from his doctor, resigned one year ago, and the Board of Trustees selected me as his replacement. Serving as chairman has been a most interesting and unusual experience. It has been educational as well as time consuming because the legislature was in session during this past January, February, and March.

Although KSMA did not cause any bills to be introduced, it would be a mistake for any member to assume that the Association had a quiet, inactive, and ineffective legislative year. As is the case on the national level, the medical profession always has the fear it will lose more from objectionable legislation than will be gained from passing our own bills.

Having been closely associated with all senators and representatives and the legislative processes in Frankfort, I realize more than ever the importance of physicians' being astute politicians. It ceases to amuse me to hear a doctor say the medical association should pass a bill to do so and so. With some inquiries, we usually find this individual is not even on a conversational status with his own senator or representative.

Until such time as *more* physicians in this state decide to become more active in politics at the precinct, county, state, and national levels, we will never have the influence to pass or prevent passage of legislation. In my opinion we have the framework devised with the legislative key man system to accomplish these tasks. I want to compliment our past state legislative chairman, Thomas P. Leonard, M.D., in 1958, Wyatt Norvell, M.D., in 1960, and Robert D. Shepard, M.D., 1962 for initiating and improving the key man system. Of course, they had the help of the efficient KSMA Headquarters staff.

Even though the key man system is an excellent plan, only about thirty per cent of the key men are effective. Many county medical societies should give more serious consideration to this system and strive to select a willing and able doctor in the future for this position. We cannot expect our KSMA lobbyist to perform miracles and get the legislators to vote to our satisfaction when we are unable to convince our senators and representatives.

We can expect our lobbyist to:

1. Become personally acquainted with the legislators and attempt to develop their confidence.
2. Become personally acquainted with the many individuals in the executive branch of the government and be in a position to get their attention when needed.
3. Get bills drafted KSMA wants introduced.
4. Become familiar with legislative processes and be able to wisely maneuver KSMA bills through the legislature.
   a. Decide which house bills may best be introduced or decide if the bill should be a companion bill and be introduced in both houses concurrently.
   b. Select a legislator (s) to sponsor the bill.
   c. Check bills with legislative research to determine if they are constitutional.
   b. Advise the sponsor(s) to proper timing to push the bill. Avoid conflicts with controversial issues.
   e. Advise sponsor on members supporting and opposing the bill.
5. Keep watch on the nearly 1,000 bills introduced during a legislative session and notify chairman on those with medical implications.
6. Help doctors who come to Frankfort contact their senators and representatives.
7. Keep chairman up to date on status of all bills we support or oppose.
8. Aid chairman in writing legislative bulletins, which are mailed to all key men, trustees, consultants, and others.
9. Talk with legislators constantly and keep doctors back home informed as to how they will vote on medical issues.

This Bobbie Grogan did superbly.

We are grateful to the thirty per cent group of key men who were instrumental in making the past session a successful one. Not a single objectionable bill with medical implications passed the legislature. Some of the more important bills are listed below, along with comments as to their progress.

HB 112 (an act permitting chiropractors to be paid for treating Workmen's Compensation cases) failed to be voted out of House Rules Committee after getting its second reading.

HB 138 (an act permitting chiropractors to participate in the Kerr-Mills Program) was voted unfavorable by the House Public Health Committee. Therefore, it was never considered by the House members.

SB 255 (an act permitting chiropractors to be paid for treating Workmen's Compensation cases) received two readings in the Senate, then returned to Rules Committee which was the automatic procedure. Effective contacts by key men on members of the Senate Rules Committee prevented this bill from coming out of Rules to the floor for a vote.

HB 179 (an act permitting optometrists to participate in the Kerr-Mills Program) passed the House 69 to 13, then was received in the Senate Rules Committee. It looked like this bill had the support needed for passage, but when the chiropractors tried to get it amended in Rules the members decided not to report it out of Committee.

SB 223, as introduced in the Senate, would effectuate policies to provide for the public health and safety from ionizing radiation. Four days before the session ended the chiropractors were successful in getting the Senate Rules Committee to include this amendment, "The Kentucky State Board of Chiropractic Examiners shall enforce rules and regulations within the profession necessary to effect compliance with state and federal regulations on ionizing radiation." This amendment would take chiropractors out from under the control of the State Board of Health. The bill as amended was killed in the House Rules Committee the day following its passage in the Senate.

HB 483 (an act relating to Workmen's Compensation) passed the House and was received in Senate Rules Committee. The chiropractors made a desperate effort to amend this bill in Rules just one day before the session ended. The amendment in effect would have been the same as passing HB 112 or SB 255. They were unsuccessful with the amendment in the Committee, and when HB 483 came to the floor for a vote, Senator Gardner, Majority Floor Leader, moved the previous question and kept off any proposed chiropractic amendments.

HB 464, as introduced in the House, would amend the present law to enable podiatrists to enter into medical service plan corporations operating in the counties in which they reside or practice. This bill did not get out of House Rules Committee for its first reading.

SB 31 was an education bill pertaining to sick leave for teachers. The chiropractors were successful in getting the Education Committee to add this amendment, "changing the term physician to licensed doctors." This would mean the chiropractors could sign sick leave certifications of teachers. We were successful in getting this bill re-committed after its third reading and just before it was to be voted on in the Senate.

HB 43 (an act which would relieve any physician

who in good faith renders emergency care, from civil damages) was killed in Senate Rules after it had passed the House 72 to 11. Our Council on Legislative Activities was opposed to this bill, or any other bill which would be constitutional, because it would not offer the protection which many physicians might interpret it to give.

SB 225 (an act prohibiting a physician from divulging confidential relations and communications between physician and patient without consent of the patient) was killed in the Senate after receiving two readings. KSMA studied this legislation about three years ago and decided it would not be a good idea to have such a bill introduced. This bill was prompted by a senior medical student's writing Senator C. W. A. McCann and asking that he introduce such legislation.

HB 453 (an act prohibiting any tax from being imposed upon or measured by the premiums paid to or received by hospital service, medical service plan or dental service plan corporations or domestic mutual insurance against risk or cost of medical and surgical care) passed and was signed by the Governor. KSMA supported this bill since it was advantageous to Blue Cross.

SB 65 (nurses bill) introduced in the Senate was never reported out of Committee and placed in the orders of the day for passage.

HB 240 (pharmacy bill) passed the House but was unable to get its first of three readings necessary in the Senate.

SB 8 (dental bill), which was a revision of a dental practice act, passed both houses and was signed by the Governor.

The 1962 House of Delegates requested the Board of Trustees to proceed with a vigorous public education program in regard to cults. The Trustees delegated the responsibility to our Council on Legislative Activities. Our attorney, Mr. Gaines Davis, did extensive research on the authentication of chiropractic treatment and the wording presented in the attached pamphlet was approved by our Council, Board of Trustees, and Council on Allied Medical Services before it was given to the printer. First printing called for 20,000 copies. Physicians have been notified through the Communicator to request the number of pamphlets needed from KSMA Headquarters. Now that the information is in distributive form, we recommend that the Council on Public Information and Service take over and make extensive distribution of the pamphlet.

I would like to thank the Board of Trustees and the Headquarters Staff for their assistance in my appointment to the AMA ad hoc committee on quackery. One meeting has been held, with another scheduled in August. All cults are of interest to this committee, but chiropractic is the primary target. It was with a deep sense of humility that I accepted this appointment, and I assure you that I shall do my utmost to justify your confidence.

Due to serving on the AMA Committee, plus other nation and state committees unrelated to medicine, I find it necessary that I reluctantly resign from this Council. I say reluctantly because I have enjoyed being a member of the Council and closely associated with the other members, who are doctors dedicated to the free enterprise system, including medicine, and who are unquestionably the most cooperative group of physicians with whom I have ever had the privilege to work. The Headquarters Staff has served our Council willingly and well, even though the hours were irregular and long. I cannot thank Bobbie Grogan enough for doing such a magnificent job in Frankfort and helping me get important information disseminated to our legislative key men, promptly. Many senators and representatives told me personally that Bobbie was the outstanding lobbyist in Frankfort. All doctors in Kentucky owe this man a "thank you" vote.

Of course, we cannot overlook the outstanding job Mitchel Denham, M.D., did as Majority Floor Leader while serving as a member of the House of Representatives this year. During my many visits to Frankfort I could see that he was highly respected and had the confidence of his fellow legislators. I think every KSMA member owes Doctor Denham a gratification of thanks.

Recommendation: Because the Board of Trustees is the policy-making body between annual meetings of the House of Delegates, I recommend that the Chairman of the Board of Trustees or the KSMA President be placed on the Legislative Council. Experience from the last legislative session would prove this to be a valuable asset since important final decisions must be made on very short notice. These decisions must have Board concurrence.

COUNCIL ON LEGISLATIVE ACTIVITIES
Branham B. Baughman, M.D., Frankfort
Walter L. Cawood, M.D., Ashland
Hoyt D. Gardner, M.D., Louisville
Daryl P. Harvey, M.D., Glasgow
David B. Stevens, M.D., Lexington
F. R. Scroggin, M.D., Dry Ridge
Chairman—State Affairs
John C. Quertermous, M.D., Murray
Chairman—National Affairs

Recommendations, Reference Committee No. 3

The first item considered by Reference Committee No. 3 was the report of the Council on Legislative Activites.

This is a review of the activities at national and state levels for the past year. We feel that the positions taken by the Legislative Council were representative of the view of organized medicine. The duties of the lobbyist listed in the report are well formulated and constitute a valid guide for our future lobbyist. The results of actions taken by the legislators on the bills enumerated reflect great credit on the planning and actions of Doctor Quertermous, Doctor Scroggin, and members of their Council.

Recommendations: Our Reference Committee considered the recommendations contained in the report and expressed their unanimous approval to continue the annual congressional dinner as in the past. The suggestion to reimburse members of the Council for their expenses to the annual dinner was thought unnecessary by all concerned parties and is not recommended. Further, the establishing of a closer liaison between the Legislative Council and the Board of Trustees was thought essential and is recommended.

Long discussions concerning this report brought out other cogent matters which the Reference Committee wishes to respectfully recommend to the House:

The key man system should be re-examined and revised by the Council to improve the effectiveness of this system beyond the 30 per cent reported. The Council should have greater freedom to select key men of interest, ability, and industry. Organizational meetings of these key personnel should be held far in advance of the legislative sessions when contacts with legislators become more difficult and less effective. In all fairness to the Council, we wish to point out that the key man system does not abrogate the responsibility of the individual member.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Council on Communications and Public Service (Paragraph 10, page 6)

(10) The necessity or the lack of it for Good Samaritan Legislation for the Commonwealth should be investigated and determined in the near future.

Recommendations, KSMA Board of Trustees (Council on Communications and Public Service)

This report was reviewed by the Board of Trustees on August 6, 1964.

BOARD ACTION: Approved with the recommendation that the Committee on Disaster Medical Care give no further consideration to the necessity for or desirability of a Good Samaritan Law.

Recommendations, Reference Committee No. 3

The next item was paragraph 10 on page 6 of the Report of the Council on Communications and Public Service. This Reference Committee considered the recommendation of a Good Samaritan Law. After discussion with the Legislative Council and the legal adviser to the Kentucky Medical Association, no need was demonstrated for such legislation.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Council on Allied Professions and Related Groups (Paragraphs 5 and 6, page 3)

The committee gave much consideration to the way in which the KSMA might work with the members of the nursing profession for the purpose of improving patient care. It reviewed the bill introduced into the 1964 Kentucky General Assembly. Your committee recommends that the House of Delegates authorize the Board of Trustees, as soon after the Annual Meeting as is convenient to be done, to explore with the Kentucky State Association of Registered Nurses and the Kentucky Hospital Association the possibility of making a study leading to the introduction of legislation designed to up-grade and improve the Nurse Practice Act in Kentucky.

COUNCIL ACTION: It is recommended that the report of the Dental-Nurse-Pharmacy Committee be accepted as presented with the exception that the words "Board of Trustees" be replaced by "Council on Legislative Activities" in the last paragraph of the report. The Council further recommends that liaison also be implemented in regard to any legislation which the pharmacists may introduce at the next session of the legislature. This should be well in advance of the next session of the Kentucky State Legislature.

Recommendations, Reference Committee No. 3

The next item was a portion of the report of the Council on Allied Professions and Related Groups.

The recommendation made by the Council was that the Council on Legislative Activities explore with the Kentucky State Association of Registered Nurses and the Kentucky Hospital Association manners of improving the Nurse Practice Act in Kentucky. It was further recommended that the liaison be implemented between the Kentucky Medical Association and the pharmacists.

The Reference Committee approves these recommendations.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion seconded; carried.)

Resolution B

Muhlenberg County Medical Society

WHEREAS, we have said it before, but

WHEREAS, there are those who would confuse the issue,

BE IT THEREFORE RESOLVED, that the Kentucky Medical Association is opposed to the extension of Social Security coverage to self-employed physicians.

Recommendations, Reference Committee No. 3

The last item considered was Resolution B, submitted by the Muhlenberg County Medical Society, opposing extension of Social Security coverage to self-employed physicians.

The Reference Committee recommends the following substitute resolve for this resolution: "BE IT THEREFORE RESOLVED, that the Kentucky Medical Association is opposed to the extension of *compulsory* Social Security coverage to self-employed physicians."

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Mr. Speaker, I move the adoption of Reference Committee No. 3 as a whole. (Motion seconded; carried.)

The Chairman wishes to thank the members of the Reference Committee who contributed so unselfishly of their time.

REFERENCE COMMITTEE NO. 3
Homer B. Martin, M.D., Louisville, Chairman
Harold B. Barton, M.D., Corbin
M. C. Loy, M.D., Columbia
James G. Sills, M.D., Hardinsburg
David B. Stevens, M.D., Lexington

At this time, Hoyt D. Gardner, M.D., Louisville, chairman of the Board of Directors of the Kentucky Educational Medical Political Action Committee, made an oral report on the progress of his organization to the second session of the House.

REFERENCE COMMITTEE NO. 4 †

Paul H. Klingenberg, M.D., Chairman

Reports on Public Service and Allied Professions

† *See note (†) bottom of column one, page 962.*

The reports this reference committee considered are as follows:

15. Report of the Council on Communications and Public Service
16. Report of the Council on Allied Professions and Related Groups

Report of the Council on Communications and Public Service

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . . ."

The material in this report of the Council on Communications and Public Service is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommedations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Communications and Public Service has held two meetings during this Associational year on January 23 and July 16, 1964.

We are pleased to welcome the Medicine and Religion Committee which has served under the Council this past year. Our remaining eight committees are: Diabetes, Disaster Medical Care, School Health, Public Health, Senior Day, Highway Safety, Advisory to the Women's Auxiliary, and the Rural Health Committee.

At our first meeting, we had as our guests Mr. William Ramsey and Mr. James Hickox of the Staff of the American Medical Association, who discussed public relations and services available to the KSMA membership from the AMA. At the request of the Council, PR Manuals were distributed from the KSMA Headquarters Office to each county PR chairman or county society secretary.

An exhibit on Medical Careers was presented at the Annual Meeting of the Kentucky School Boards Association in March and again at the Kentucky Education Association Meeting in April. KSMA will also participate in Health-O-Drama at the State Fair this year and a new exhibit on the Emergency Medical Identification Symbol will be presented at the 1964 KSMA Annual Meeting.

Also, at the first meeting, guidelines on the KSMA Orientation Course were submitted to the Bylaws Committee for drafting an addition to the KSMA Bylaws. A Sub-Committee on Orientation was appointed to formulate the methods of implementing the Orientation Course. The Council members approved a statement of the duties for each committee serving under the Council and submitted them to the Board of Trustees for inclusion in KSMA policy.

Other actions taken by the Council and approved by the Board of Trustees included:

1. That the Kentucky State Medical Association endorse commercial advertising under the auspices of the state association and/or county medical societies concerning public service programs in medicine such as emergency calls, house call problems, etc., dealing in good taste with factual medical problems; and
2. That KSMA Trustees send out a letter to new members in their district welcoming them to the Association and offering the services of the KSMA officers and staff.

At its second meeting, the council discussed exhibits sponsored by KSMA and recommends that the presentation of exhibits at the 1965 meetings of the Kentucky Education Association and the Kentucky State Fair be continued as they have been in the past. However, the council recommends that exhibiting at the Kentucky School Boards Association be terminated because of a lack of interest demonstrated by those attending the School Boards' meeting.

The Council discussed Community Health Week which will be held nation wide October 18-24, and approved the concept of this program. It is suggested that an article on Community Health Week appear in the KSMA Journal and that a newspaper release be sent to all daily and weekly newspapers.

It was brought to the Committee's attention that the Council on Legislative Activities had referred the "Some Questions and Answers about Chiropractic" pamphlet to this council for distribution. It is our recommendation that these pamphlets be made available to the members of KSMA for their use by distribution at committee meetings, medical meetings, announcements through KSMA publications, etc.

We again discussed the Mandatory Orientation Program approved by the 1963 House of Delegates and the Council appreciates the efforts of its Sub-Committee on Orientation in drafting guidelines and a tentative program for implementing the Orientation Course. We recommend that the following tentative program as outlined by the Sub-Committee on Orientation be accepted and implemented on the Monday preceding the 1965 KSMA Annual Meeting.

Tentative Program
KMA Mandatory Orientation Course

	Chairman Moderator—To introduce topics & speakers
8:00 a.m.	Registration
8:30 a.m.	Welcome and Introduction — KSMA President Structure — Function — Policies of organized medicine
8:35 a.m.	County (15 minutes—KSMA member or President of one of larger county societies) KSMA (15 minutes—Executive Secretary or KSMA member) AMA (15 minutes—AMA officer or representative or KSMA member)
9:20 a.m.	Public Relations (KSMA member—30 minutes)
9:50 a.m.	Health Insurance (commercial representative—15 minutes)
10:05 a.m.	Health Insurance (Blue Cross & Blue Shield—15 minutes)
10:20 a.m.	COFFEE BREAK
10:30 a.m.	Medical Ethics (KSMA member—30 minutes)
11:00 a.m.	Medico — Legal Aspects (Lawyer — 30 minutes)
11:30 a.m.	Medico—Press Relations (Press, TV, Radio—member of Press—30 minutes)
12:00 noon	Lunch — Sponsored by KSMA (ask wives of candidates — Presentation by President of KSMA's Women's Auxiliary —15 minutes)
1:20 p.m.	Re-registration
1:30 p.m.	Legislation and Political Medicine Legislative Information (AMA Washington Office representative—15 minutes)
1:45 p.m.	Kerr-Mills Bill (KSMA member—15 minutes)
2:00 p.m.	King-Anderson Type Legislation (KSMA member—15 minutes)
2:15 p.m.	KSMA Key Man System—State Legislature (KSMA member—15 minutes)
2:30 p.m.	Question-and-Answer Period or ADJOURN

We further recommend that a Committee on Orientation be formed to serve under this council. We have reviewed and expressed our approval of the addition to the KSMA Bylaws as drafted by the Bylaws Committee pertaining to the Mandatory Orientation Course.

The following reports of the committees serving under this council are herewith submitted:

Diabetes Committee, Robert S. Tillett, M.D., Louisville, Chairman

The Diabetes Committee of the Kentucky State Medical Association scheduled a meeting for June 10; however, it became necessary to cancel the meeting since a quorum could not be present.

Since the promotion of the annual Diabetes Detection and Education Week has remained basically the same since the program was initiated 13 years ago, it is the chairman's recommendation that a similar promotional program be conducted for the 14th Annual Drive during 1964. The Diabetes Detection and Education Drive will be held this year during the week of November 15-21.

We would like to take this opportunity to extend our appreciation to the diabetes chairmen of the county medical societies, all KSMA members, and all of the cooperating organizations that helped us make the 1963 Diabetes Drive the most successful one we have had to date.

During our campaign last November, 96,333 tests were administered and reported to the KSMA Headquarters Office. Of this number, 1,174 proved to be

positive and 191 were newly found diabetics. We are also pleased to report that 95 county diabetes chairmen were appointed and reported to us last year. This enabled us to coordinate the efforts of nearly every county in Kentucky and was one of the prime reasons for our successful campaign.

It is our feeling that the KSMA Diabetes Detection and Education Week is one of our outstanding public service programs and certainly focuses public attention on the Kentucky State Medical Association. Last year our promotional effort resulted in nearly 400 newspaper clippings received in the KSMA Office. We are hopeful that the physicians in Kentucky will continue their cooperation and help make our drives in 1964 and the years to come as successful as the one this past year.

Recommendations, Reference Committee No. 4

The Diabetes Detection and Glaucoma Test at the State Fair has been very successful. Consideration of the Blood Sugar Analysis by rapid finger blood sampling may be considered by this Committee in the future.

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Diabetes Committee as presented. (Motion seconded; carried.)

Committee on Disaster Medical Care, William T. Rumage, Jr., M.D., Louisville, Chairman

The chairman and members of the committee wish to commend the efforts of the staff of the Kentucky State Medical Association in making this such a productive year. However, it is apparent that additional money and staff time are needed if the Kentucky State Medical Association's disaster plans for the Commonwealth are to be effective. There should also be a cooperative balance between the efforts of various governmental and private agencies and the medical profession in disaster preparedness. Adequate funds should be made available by the governmental agencies. The responsibility lies with the Kentucky State Medical Association to do whatever it can to foster preparedness for the frequent natural disasters which occur. Preparations for naturally occurring disasters (plane accidents, storms, fires, etc.) should have primary consideration. It seems obvious that if the medical profession does not take the lead in this problem, that the government will.

Listed below are some of the items which received attention by the committee. They are not listed in order of importance:

(1) The name of the committee was changed to correspond more closely to the AMA's Committee on Disaster Medical Care.

(2) The purpose and objectives of the committee were written and submitted.

(3) The membership of the committee has been changed and increased. Guests from various governmental and private agencies concerned with medical care have visited the committee meetings.

(3a) We are particularly concerned with the neglect of the request to the Health Department to supply Emergency Kits to the Flying Physicians. These kits could be bought from surplus for a very small amount of money.

(3b) We have had a very worthwhile relationship with the Medical Education for National Defense representative at the University of Louisville and plans should be made by future committees to participate in the program at that school and in turn for students and health officers to attend the Kentucky State Medical Association's Committee on Disaster Medical Care meetings. Unfortunately, our efforts to establish relationships with the Medical Education for National Defense representative at the University of Kentucky have gone unanswered.

(3c) The check list as written by the American Hospital Association and the American Medical Association for hospitals for disaster plans which was reviewed by this committee, has been approved nationally and is now available for distribution. Every doctor across Kentucky should ask his hospital administrator about the disaster plans for his hospital.

(3d) Relationships with the Kentucky Hospital Association Disaster Planning Committee have continued. Future committees should determine the extent of inventories of Hospital supplies and equipment which are practical to maintain.

(4) The Civil Defense Emergency Self-Help Training Program has been conducted and the hospital has been demonstrated in 10 counties. Additionally, the hospital will be demonstrated at the KSMA Annual Meeting for 1964.

(5) Thirty three of the Civil Defense Emergency Hospitals are now assigned to Kentucky. A chore of future committees might be to assist the local communities in arranging for staff coverage and in the development of a community disaster plan to incorporate a Civil Defense Emergency Hospital.

(6) The Medical Self-Help Training Program has continued and at the present time 5,020 people have completed the course.

(7) A special issue of the Journal of the KSMA devoted to disaster planning has been written and enthusiastically received nationally.

(8) Future committees should seriously consider moving the meeting place across the state. This might have professional influence on that area to develop its own disaster plans. Additionally, committee meetings using the Telephone Conference System should be considered. Interim Meetings are held in this manner in both Massachusetts and Pennsylvania. In as much as the Association has refused to permit funds for such a telephone conference, the members of the committee would probably be willing to pay the telephone toll involved.

(9) The availability of reserve and retired officers to assist in disaster planning should be explored. Credits toward their retirement could be achieved in this manner.

*(10) The necessity or the lack of it for Good Samaritan Legislation for the Commonwealth should be investigated and determined in the near future.

(11) The KSMA Committee on Disaster Medical Care continues to be represented on the Governor's Task Force for Health although the present administration has indicated no interest in disaster planning to this date.

(12) The basement of the Kentucky State Medical Association Headquarters Building has been examined by this committee and the State Department of Health as a possible shelter. No action was taken because of the possibility of making this area part of the Central Communications Network for Disaster Planning across the state.

(13) Correspondence has been conducted with the Kentucky Public Health Association, Kentucky Hospital Association, and the Rural Health Council in high hopes that matters of disaster planning would be incorporated in their meetings.

(14) The committee has heartily endorsed the concept of the Emergency Identification tag.

(15) The committee urges that a resolution be passed concerning the development of uni-

Note: This item was referred to Reference Committee #3.

form highway signs and map markers indicating available hospital Emergency Rooms. With the Development of the inter-state highway system and the continuing increase in trans-continental automobile travel, the importance of nearby emergency medical services is obvious.

Recommendations, Reference Committee No. 4

The Resolution involving uniform highway signs will be reported by another committee. The problem of the Good Samaritan Legislation as noted in paragraph 10, page 6, has been referred to another committee.

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report on Disaster Medical Care as presented. (Motion was seconded and carried.)

Highway Safety Committee, Arthur H. Keeney, M.D., Louisville, Chairman

The activities during the past year of this committee have centered around the basic areas of Medical Aspects of Driver Limitation, a Kentucky-Cornell A.C.I.R. Program, and a new program of conjoint effort with attorneys in Kentucky. Following is a tabulation of specific undertakings of the committee during the past year:

(1) *Kentucky-Cornell Automotive Crash Injury Research Program.* This program was initiated August 1, 1962, and entered its fourth phase on February 1, 1964 during which time the program will be activated for another six-month period in thirteen additional counties. The program to date has involved nearly 500 single-car accidents and over 200 multiple-car accidents in which approximately 1,300 persons have been injured and 50 have been killed. The quality of reporting by Kentucky physicians and Kentucky State Troopers has been excellent. This program is scheduled to continue for the full three years. The chairman of this committee will meet with the Cornell officers in Buffalo, New York, at the Cornell Aeronautical Laboratories, on July 31 and August 1, 1964, at which time Cornell will be host to the American Medical Association Committee on Medical Aspects of Automotive Safety.

(2) *Medical Aspects of Driver Limitation.* Third revision of the "Statement of Position of the Kentucky State Medical Association" was issued by the KSMA Headquarters Office in January, 1964, bringing up to date the activities and thinking in this regard. There have been many requests for the statement of position from other states and interested organizations. The Trustees of the AMA adopted the Kentucky program in November, 1963, and the AMA House of Delegates similarly adopted this program as a prototype to be recommended by the American Medical Association. This program was published in the JAMA, 187:376 (February 1) 1964.

A meeting was held in the office of the Commissioner of Health, December 5, 1963, with the Commissioners of Health and Safety, at which time a television reel was made concerning the initiation of this program and press releases were distributed to Kentucky newspapers.

Former Department of Safety administrative regulations (D1-6, D1-7, D1-8) became effective June 11, 1964, under KRS 186.400.

(3) At the annual KSMA meeting in Lexington, September 24 to 26, 1963, highway safety exhibits were arranged by the committee for the (a) Department of Public Safety, (b) Cornell Automotive Crash Injury Research Program, and (c) The Irving Airchute Company of Lexington. These exhibits all received good attention and forwarded the cause of safety.

(4) In December, 1963, the National Safety Council awarded its 1963 Surgeons Award for Distinguished Service to Safety to Doctor R. Arnold Griswold of this committee for his long contributing aid in the field of automotive safety. This cited Doctor Griswold as "surgeon, teacher, veteran of two world wars, father of the seat belt resolution of the American College of Surgeons."

(5) At the request of the Jefferson County Police Department, a seminar on the handling of injured persons was held December 17, 1963, and was participated in by Louisville members of the committee, instructing all the Jefferson County police force in two shifts.

(6) At a meeting called by the chairman on February 21, 1964, the presidents of the Louisville Bar Association and the Kentucky State Bar Association were requested to join forces with the KSMA in accordance with instructions issued by the committee at the meeting January 30, 1964. Both of these officers expressed complete willingness. The Louisville Bar Association met on March 7, 1964, and passed the following resolution. The Kentucky Bar Association meeting in April, 1964, also passed a similar resolution and created a Vehicular Safety Committee reporting through the Kentucky State Bar Association annually to the American Bar Association. Similarly, the National Association of Claimant's Compensation Attorneys, in national session in February, 1964, established a Committee on Legal Aspects of Automotive Safety and appointed Mr. Theodore Wurmser, of this city, as chairman to coordinate national level works with NACCA and the American Medical Association. Mr. Wurmser is the Sixth District Governor for the NACCA Bar Association.

LOUISVILLE BAR ASSOCIATION

Resolution

March 5, 1964

WHEREAS, many principles to be applied for the reduction of crash injuries in motorcars have been documented for over thirty years, have been in use in aviation practice for fifteen years, and have been presented in various medical publications since 1934; and

WHEREAS, these principles are a part of basic engineering knowledge, and have been brought to the attention of executive personnel in the motorcar industry by medical, engineering, police, safety, and other groups many times; and

WHEREAS, the motorcar industry gave only minimal recognition to these principles and practices in its products for the 1956 model year, even though automobiles are more readily changed than human behavior or highways and traffic laws,

BE IT RESOLVED that the Louisville Bar Association firmly requests the Automobile Manufacturers Association (320 New Center Building, Detroit 2, Michigan) to incorporate as *standard* equipment for all American motorcars those safety devices, structures and modifications which have been clearly recognized for their reduction of injury and deaths on our roads, and further requests the National Automobile Dealers Association (2000 K Street, N.W., Washington 6, D.C.) to pledge the purchase and sales of cars only when fitted with these acknowledged modifications.

BE IT FURTHER RESOLVED that the Louisville Bar Association pledges the continued operation of a Vehicular Safety Committee to review the action of industry chairmen, presidents, and dealers in this regard and report annually through the Kentucky Bar Association to the American Bar Association on the effectiveness of such injury-reducing designs.

On April 21, 1964, the Kentucky Association of Trial Attorneys produced a seminar on "Product Liability" and a panel composed of Doctors Griswold, Keller, and Kenney represented the medical aspects of automotive injuries to this group. This was a successfully attended meeting with good response from the attorneys in this association.

(7) No significant or truly satisfactory accomplish-

ments have yet been realized in the matter of basic vehicular design modifications. It is still the deep conviction of this committee that the automobile should be a relatively safe place in which to have an accident and it is the conviction of this committee that chairmen of the board, vice-presidents in charge of sales and vice-presidents in charge of design of the major automotive manufacturers must be won to this point of view.

(8) The committee wishes particularly to thank the media which have given such splendid coverage to the activities of the committee during the past year, including:

WAVE hour-long question and answer program, November 8, 1963, 8:00-9:00 p.m.

Lemme-do-it column devoted to driver limitation, Louisville Times, March 26, 1964.

Medical World News, February 14, 1964, page 54.

Greensburg Record-Herald, January 24, 1964.

Bulletin of the American Association of Motor Vehicle Administrators, January, 1964, page 78.

Medical Tribune, on frequent occasions.

This committee also wishes to thank Doctor Paul V. Joliet, Chief, Accident Prevention Division, US Public Health Service, for the complimentary recognition of the Kentucky program and for the meeting arranged here in Louisville with his Research Psychologist, Doctor Louise Thompson, June 4, 1964.

The Committee requests:

(1) Approval of the program to date by the Council on Communications and Public Service, with endorsement of continued activities along these lines;
(2) Authority to develop a conjoint Kentucky State Medical Association and Kentucky Bar Association program in automotive safety;
(3) That sincere or thoughtful suggestions on the part of any physician or individual of the commonwealth concerning highway safety be transmitted to this committee for assistance and evaluation. The committee respectfully solicits any comments from the membership and officers of the Association; and
(4) The Kentucky State Medical Association membership to particularly note the forthcoming annual meeting of the American Association for Automotive Medicine to be held at Stouffer's Louisville Inn, October 26-27, 1964; the president of this organization is Doctor William K. Keller, a member of this committee.

Recommendations, Reference Committee No. 4

This committee concurs with the principles submitted by the Louisville Bar Association in March of 1964. All efforts to achieve seat belts of the shoulder and waist variety are necessary.

Mr. Speaker, Reference Committee No. 4 moves the adoption of the Highway Safety Committee as presented. (Motion seconded; carried.)

Committee on Medicine and Religion, William L. Woolfolk, M.D., Owensboro, Chairman

This committee was formed in the summer of 1963 and had its first meeting at the KSMA Building in Louisville during that summer with Mr. Arne Larson of the AMA present. Mr. Larson explained to the committee in detail the purpose of this new AMA Committee. The committee members then decided to have each committee member sponsor a meeting of Medicine and Religion in his respective County Society. The physicians in the surrounding counties were to be invited. A second meeting of this committee was called for October 21, 1963 in Louisville at the time of the Jefferson County Medicine and Religion meeting. Unfortunately, only Doctor Keen of Bowling Green, and Doctor Woolfolk of Owensboro, were present at that meeting with the Reverend Doctor Paul McCleave. Due to the fact that a quorum was not present, no additional business was transacted.

In addition to the Jefferson County meeting in October, 1963, the only other County meeting on Medicine and Religion was held by the Daviess County Medical Society on April 28, 1964.

I have recently had a letter from Doctor Joe Saunders of Lexington, telling me that his society is planning a meeting on Medicine and Religion in the near future. Doctor Saunders also suggested that the committee have a small booth at the KSMA Meeting in September, which would be staffed by members of the committee in order to explain the committee's purpose to any members who are interested.

We are planning another meeting of the committee at the time of the KSMA Meeting in Louisville, and hope to have Mr. Arne Larson present.

Mr. Larson informed me that the North Carolina Medical Society is planning a TV broadcast during the fall on the subject of Medicine and Religion. Mr. Larson expects to explain this phase of the work at the meeting expected to be held during the KSMA Meeting.

It is regrettable that only two county meetings have been held during the past year, but it is to be remembered that many societies have their programs made up a year or more in advance.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Committee on Medicine and Religion as presented. (Motion was seconded and carried.)

Public Health Committee, M. A. Shepherd, M. D., Somerset, Chairman

On March 19, 1964, the committee met with Russell E. Teague, M.D., Commissioner of the State Department of Health, and Mr. Robert G. Cox, in the KSMA Headquarters Office and decided upon certain actions and recommendations.

It was agreed that KSMA should not only continue to promote Immunization Week in Kentucky, but that we should stimulate each county medical society to have an Immunization Committee. The said committee should work with the local board of health to develop a year-round immunization program designed to get all children immunized before one year of age and to maintain boosters for life.

The committee recommended that a letter should go out to all county societies from the President of KSMA depicting the dire need for better reporting of syphilis to the responsible VD investigators.

The committee concluded that KSMA's most effective approach to controlling disease produced by smoking is through providing family physicians with the facts. With this in mind, the committee recommends to the Board of Trustees through the Council on Communications and Public Service that a symposium on "Tobacco and Health" be scheduled for the 1965 Annual Meeting, and further recommends that if approved by the Board, the request be made known to the Council on Scientific Assembly.

COUNCIL ACTION: The Council takes cognizance of the statements presented in this report concerning a symposium for the 1965 Annual Meeting and feels that this should be forwarded to the Scientific Program Committee for their consideration without council action.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Public Health Committee as presented. (Motion was seconded and carried.)

Rural Health Committee, Donald L. Graves, M.D., Frenchburg, Chairman

The main function of this committee is that of assisting and guiding the Kentucky Rural Health Coun-

cil. Since the council promotes a rural health conference annually, we realize the importance of a close working relationship with the members of the various organizations.

The council consists of twenty-five organizations, and promoting the annual conference is a good way to work with the many groups. The conference presents a means of getting better acquainted with each group's membership and permits us to solicit their help in promoting better health conditions of people in rural areas.

Almost yearly the conference's total attendance increases, and we think this is due to the types of programs which are presented. We now strive to get more local talent to appear on the program, and we also attempt to deal more with the local problems where the conference is being held.

Ever since the Rural Health Council has been organized, the chairman has been a medical doctor and usually he is chairman of this committee. We now feel that the group's working relationship is coming of age and we should take advantage of excellent talent from other organizations. Mr. John Koon, Executive Secretary of the Kentucky Farm Bureau, was selected chairman for this year. We feel this change will stimulate further interest in the council members outside of medicine.

Our committee has had two meetings since the last session of the House of Delegates. One was on October 23, 1963 and the second was May 21, 1964. The purpose of the first meeting was to work out the last-minute details of the 1963 conference program. The second meeting was to have the committee brought up to date on plans for the 1964 conference and make suggestion for any improvements.

This year's meeting will be held on October 22 at the University of Kentucky Medical Center. The type of program will be given to "Opportunities in Health Careers." We might say that although KSMA's Committee on Rural Health has been one of the major forces in the annual conference, the attendance of doctors has been very low through the years. All physicians in driving distance of Lexington who possibly can are urged to attend the careers program on October 22.

Mitchel Denham, M.D., and I represented this committee at the National Rural Health Conference held at Columbus, Ohio, on March 6-7, 1964. Nine other Kentuckians attended and all of us agreed that this was a most outstanding meeting. Next year's national conference will be held in Miami, Florida, in March.

I feel this informal last paragraph is indicated. It has occurred to me that the folks in the Headquarters Staff probably don't get many thanks and I'm sure even though they realize we appreciate their indispensable work, and assistance in all the paper work, we sort of expect it of them and take them for granted. So this committee wants to extend our most sincere thanks to them for their day by day duties that make the KSMA work of its committees and councils possible and as successful as they may be.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Rural Health Committee as presented. (Motion seconded; carried.)

School Health Committee, R. E. Davis, M.D., Central City, Chairman

The KSMA School Health Committee has met twice this year, once January 9 and again on April 2. At our first meeting, we discussed the Athletic Injury Prevention Conferences we have held in the past and again offered our services to the Kentucky High School Athletic Association for additional conferences this year and in the future.

We are happy to report that the Board of Trustees approved our committee's request to sponsor an Association of Team Physicians on the Medical Aspects of Sports. This organization is now being formed under the chairmanship of O. B. Murphy, M.D., Lexington. We are also pleased that our recommendation of last year to have a symposium on Athletic Injury Prevention for the 1964 KSMA Annual Meeting was approved and this symposium will be held Thursday afternoon, October 1 at 2:00 p.m. in the Convention Center, Louisville.

The House of Delegates expressed KSMA's interest in physical education for our school system last year when a resolution on this subject was passed. Your School Health Committee is interested in seeing a state-wide physical fitness program initiated in Kentucky Schools and had Mr. Don Bale, Assistant Superintendent of Public Instruction for the Commonwealth of Kentucky, as a guest at our second meeting to discuss this program. We have volunteered our assistance toward seeing such a program becoming a reality.

The chairman wishes to acknowledge the invaluable assistance and cooperation given him by members of the committee this year.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the School Health Committee as presented. (Motion seconded; carried.)

Senior Day Committee, Donald Chatham, M.D., Shelbyville, Chairman

The Senior Day Program was presented to the University of Louisville Medical School graduating seniors on March 16, with the program beginning in the Rankin Amphitheater, Louisville General Hospital and the afternoon session at the Medical Arts Building auditorium.

In general, the program went well, and was received with enthusiasm on the part of the students. Their criticism sheets were passed out to the students and received after the program with some helpful suggestions elicited, which will try to be used in forming next year's program.

The evening speaker was Harlan English, M.D., President of the Illinois State Medical Society, who spoke on the subject of "The Practice as I see It." Doctor English was well received by all present and certainly presented a profitable hour's program to us.

The same program was presented to the seniors at the University of Kentucky Medical School, Lexington, on April 14, with much the same response as was gotten from the Louisville group. On this occasion, also, the students offered some helpful suggestions for next year's program. Herbert Sloan, M.D., was the feature speaker at the University of Kentucky evening program. Doctor Sloan is associated with the University of Michigan School of Medicine.

Both of these Senior Day Programs were gotten off to an excellent start with a speech presented by Doctor George Archer, President of KSMA, who brought a very enlightening and informative paper on his experiences as President of KSMA. It would be worthwhile if all KSMA members could hear Doctor Archer's talk.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Senior Day Committee as presented. (Motion seconded; carried.)

Advisory Committee to the Woman's Auxiliary, J. Andrew Bowen, M.D., Louisville, Chairman

Your Advisory Committee to the Woman's Auxiliary has had no requests for advice and naturally has not voluntarily offered any advice.

Since there has been no business to be discussed, no meetings have been held.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Advisory to the Woman's Auxiliary Committee as presented. (Motion was seconded and carried.)

As chairman, I would like to express my appreciation to all of those who served on the Council and to commend the committees that have served under the Council for their work during the Associational year.

The Council on Communications and Public Service is charged with the responsibility of supervising and directing all Association activities in the field of Public Relations and Services.

COUNCIL ON COMMUNICATIONS AND PUBLIC SERVICE
Donald Chatham, M.D., Shelbyville
R. E. Davis, M.D., Central City
Donald L. Graves, M.D., Frenchburg
Arthur H. Keeney, M.D., Louisville
William T. Rumage, Jr., M.D., Louisville
Robert S. Tillett, M.D., Louisville
N. Lewis Bosworth, M.D., Lexington, Chairman

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the entire report of the Council on Communications and Public Service, including Board Action of page 17. (Motion was seconded and carried.)

Report of the Council on Allied Professions and Related Groups

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the Bylaws, which reads in part:

". . . . Each standing committee and council shall report annually at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees, respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make . . . ."

The material in this report of the Council on Allied Professions and Related Groups is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * * *

The Council on Allied Professions and Related Groups met once during the Associational year on July 9. Members of the Council approved a statement of duties for each of the committees serving under the council for consideration by the Board of Trustees at their August 6 meeting for inclusion in KSMA policy.

The Council then discussed the activities of its committees and reviewed their final reports. The committees serving under the Council are: Dental-Nurse-Pharmacy Committee, Physical Medicine and Rehabilitation Committee, Infant and Maternal Mortality Committee, Tuberculosis Committee, Blood Banks Committee, and Industrial Medicine Committee.

The following are the final reports of these committees:

Dental-Nurse-Pharmacy Committee, Melvin J. Weber, M.D., Ludlow, Chairman

The committee held one meeting during the past Associational year and all but one member was present. As a result of this session, the following recommendations are made to the House of Delegates:

Liaison with the Pharmaceutical Association

Representatives of both the Kentucky Pharmaceutical Association and KSMA attended the National Congress on Medicine and Pharmacy sponsored by the AMA. Following this congress, the Association received a letter from the President of the pharmaceutical association suggesting that committees from these organizations meet to consider our mutual problems and urged that a voluntary inter-professional code of conduct be formulated and adopted.

Your committee after considering this matter very carefully, asks the House of Delegates for the authorization to meet with the Pharmaceutical Association for the purpose of studying our joint problems and the consideration of the establishment of a voluntary inter-professional code of conduct.

As a means of helping orient future physicians on the matter of working with the pharmacists to better serve the patient, your committee recommends that a pharmacist be placed on the Senior Day Program for both schools in future years, starting with 1965.

Your committee gave careful consideration to the matter of physicians becoming involved in financial affairs of the pharmaceutical industry. It recommends that the KSMA House of Delegates endorse and support the position taken by the AMA House of Delegates as reported in the June 22, 1964 issue of the AMA News:

The House of Delegates statement provided in part:

"*Pharmacies*—It cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

"*Drug Repackaging Companies*—It is unthical for a physician to have a financial interest in a drug repacking company.

"*Pharmaceutical Companies*—It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine."

The AMA Judicial Council last November further said, "The term 'repackaging company' as used by the Judicial Council and approved by the House of Delegates refers to a drug company which markets under its own label or trade names drug products manufactured by others with the objective that physicians having a financial interest in the drug company will prescribe its drugs to the patient."

The committee gave much consideration to the way in which the KSMA might work with the members of the nursing profession for the purpose of improving patient care. It reviewed the bill introduced into the 1964 Kentucky General Assembly. Your committee recommends that the House of Delegates authorize the Board of Trustees, as soon after the Annual Meeting as is convenient to be done, to explore with the Kentucky State Association of Registered Nurses and the Kentucky Hospital Association the possibility of making a study leading to the introduction of legislation designed to up-grade and improve the Nurse Practice Act in Kentucky.

COUNCIL ACTION: It is recommended that the report of the Dental-Nurse-Pharmacy Committee be accepted as presented with the exception that the words "Board of Trustees" be replaced by "Council on Legislative Activities" in the last paragraph of the report. The Council further recommends that liaison also be implemented in regard to any legislation which the pharmacists may introduce at the next session of the legislature. This should be well in advance of the next session of the Kentucky State Legislature.

Recommendations, Reference Committee No. 4

Paragraphs 5 and 6 on page 3 have been referred to another committee.

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Dental-Nurse-Pharmacy Committee as presented. (Motion seconded; carried.)

Physical Medicine and Rehabilitation, William K. Massie, M.D., Lexington, Chairman.

Rehabilitation is designed to fit a patient for employment within his capability in the shortest possible time. Following an illness or injury, each patient has a dual impairment: a) a specific impairment to the affected part; b) temporary general decrease in work tolerance resulting from inactivity. The doctor's attention is almost wholly concerned with treating the specific impairment. When, however, the general work tolerance is impaired severely, the patient will not meet the requirements of full employment in acceptable time without supervised rehabilitation. Facilities for providing this service in Kentucky are too few, too expensive, and for the most part, offered on an in-patient basis. More important, however, these inadequate facilities are not overworked. We can only conclude that all concerned, patient, doctor, and compensation carrier, are in general not cognizant of the tremendous waste in man hours of work resulting from the presently accepted method of self-rehabilitation. Medical rehabilitation discontinued before re-employment swells the lists of those placed permanently on welfare, or given social security prematurely for medical disability.

The committee, on considering this problem, was immediately impressed with the many ramifications. It seems obvious that rehabilitation must terminate in re-employement to justify its expense. A patient not returnable to his original work status must be re-trained, and if re-trained, must frequently be re-located to obtain employment. Hence, all these factors must function as a unit. This assumes, however, that all patients are motivated to work at their optimum physical capacity. This is incorrect. Barriers to re-employment are less medical than psychological. The more that is done for the patient, the less he will do for himself.

Recent economic trends in legislation have been toward giving the disabled more economic security by providing monetary relief to which he is entitled by virtue of citizenship alone. No work is demanded on the part of the patient; in fact, if he should work for hire, he is automatically disqualified for supplementary relief. The premium placed on disability, therefore, is obvious, and could eventually destroy the last vestige of motivation.

This committee rapidly concluded that any efforts to increase the facilities and the demand for rehabilitation in the Commonwealth must be multi-directional and sustained sufficiently long to obtain the objective. Since our objectives might coincide with those of other committees, we will outline them briefly so that the Allied Council might better coordinate our efforts.

1. *Disseminate to all KSMA members available facilities within the state* for rehabilitation and the expected per diem cost. Provide a simple directory to each physician to allow him to properly direct his patient to available facilities in re-training, re-employment and re-location. This might be done in an article in our Journal and also outline the information on a patient which might be reasonably expected in a report from such a Center. This would aid the physician in determining the impairment rating and the probable work tolerance.

2. *Inform insurance companies at their annual meetings of the financial advantages of quickly and routinely rehabilitating each patient* requiring such supervision, rather than delegating this to untrained relatives and friends. They must be convinced: a) that the expense of rehabilitation would be offset by the decreased number of weekly payments required before the patient returns to work; b) that impairment ratings would be more accurate after prolonged observation of the patient in working conditions, yet the elimination of any temporary impairment before the rating would probably reduce the final permanent rating.

3. *Meet with state officials of rehabilitation, re-training, re-employment, re-location, and welfare* to formulate a plan of concerted action for each patient, designed to terminate in re-employment. It is here that performance and job matching must be considered. In this computer era, all aspects of patient performance could be tabulated at completion of a course in rehabilitation by the rehabilitation department. Likewise, groups of employers could tabulate requirements for many types of jobs in the same terms. By such electronic matching, the patient with specific limitations might be offered several alternative job openings.

4. *Investigate the possibilities of motivating the disabled.*

A. *Measures to enhance motivation.*

(1) Disability evaluations for compensation patients vary widely between examining physicians. This produces several undesirable features. Physicians become known either as "insurance" or "plaintiff" doctors. It has become a common practice to sum the varying disability ratings and divide in half. This stimulates the patient to seek legal aid routinely, thus putting an undue burden on the courts and unjust expense on a patient who needs compensation badly. A committee could be appointed to investigate a standard which all physicians could follow to render impairment ratings based on purely clinical findings. A professional disability board could then use these physician impairment ratings to correlate the many variables, such as age, education, type of job, socio-economic status, etc., to render a true disability rating.

(2) On the job rehabilitation has been practically eliminated by both the employer and the union. The work tolerance of a long disabled patient can be partially raised at a rehabilitation center. To bring this work tolerance up to the level of heavy labor in such a center is expensive and often impossible. If such a patient, not able or job-situated to return to unrestricted labor, does return to light work under a temporary partial disability status, receiving dual compensation from both the employer and the insurance carrier, he might be returned more rapidly to full activity. This, though, incorporated in the present Workmen's Compensation Law (342.100) is rarely practiced, because of opposition by the employer, insurance carrier, and union.

(3) The patient under some conditions can manipulate welfare to obtain as much compensation for unemployment as he could by working full-time. Often he exceeds full-time pay during the slow season. Would not work relief, substituted for this welfare, discourage this practice? Currently in 9 counties, work relief combined with a daily period of retraining is practiced on a trial basis. The results to date are most encouraging.

B. *Measures now in force which effectively stultify motivation:*

(1) The partially disabled patient may be unable to compete for a full-time job. If he accepts welfare, he must not work. Also a patient on social security below the age of 70 must either forego work or social security payments.

(2) A patient with an impairment amenable to medical treatment may refuse such treatment, accepting an impairment which makes him unfit for labor, but does not disqualify him for wel-

fare. Likewise, a patient unable to obtain suitable employment in his location may refuse employment offered him at a distance, but he remains eligible for welfare.

The above problems are all pertinent to rehabilitation. In fact, rehabilitation cannot be considered apart from them. As a Rehabilitation Committee, we are considering each of them in sub-groups. Since our objectives have been only formulated, and are yet unaccomplished, we as a group would like to participate in next year's Rehabilitation Committee. We feel, however, that additional members would be most desirable, so that the many sub-groups could be composed of physicians so dissatisfied with the status quo that they will give time and thought to rectifying it.

For the first time in many years, the federal government made available $90,000 more than would be matched by state funds on a 3:1 basis.

MEASURES FOR SPECIFIC ACTION BY KENTUCKY STATE MEDICAL ASSOCIATION

1. Appoint a disability committee to investigate and propose a standard for impairment ratings.
2. Request the Journal to prepare a series of articles designed to inform the physicians of a) current rehabilitation facilities, costs, and services; b) agencies available for re-training, re-locating, and re-employment of partially disabled patients currently swelling the lists of the Welfare agencies.
3. Support the recent effort of the Commission on Education to substitute work relief plus re-training for Welfare.
4. Publicize the little used section of the Workmen's Compensation Law 342.100 (on the job rehabilition) as an adjunct to formal rehabilitation.
5. Request state government to match all available federal funds for rehabilitation.

COUNCIL ACTION: It is recommended that the report of the Physical Medicine and Rehabilitation Committee be accepted as presented. The Council requests that the chairman of this committee submit a list of nominees to the Board of Trustees for membership on the Committee on Disability which is recommended in this report.

Recommendations, Reference Committee No. 4

There appears to be very much to gain from the formation of a Disability Committee to investigate and propose standards for impairment rating.

Mr. Speaker, Reference Committee No. 4 moves the adoption and implementation of the report of the Physical Medicine and Rehabilitation Committee as presented. (Motion was seconded and carried.)

Infant and maternal mortality committee, Barton L. Ramsey, Jr., M.D., Somerset chairman.

The Maternal Mortality Committee has met quarterly during the past year. The subcommittee on infant mortality met at one time during the last year. Pediatricians on this committee want to select their chairman with the approval of KSMA and move forward with the study of infant mortality in Kentucky. The members of the Infant Mortality Committee helped start a postgraduate program in June, 1964, at the University Hospital in Lexington, Kentucky. This program is for nurses giving newborn care at any hospital in Kentucky. They have had their first class.

The present Committee on Infant and Maternal Mortality has found it impossible to cover both functions and has in effect functioned as two separate committees from the beginning. In accordance with the recommendations of the American Medical Association, we recommend that the Infant and Maternal Mortality Committee be organized into two separate committees: A Maternal Mortality Study Committee and a Perinatal Mortality and Morbidity Study Committee.

The annual report of the Kentucky Mortality Committee is presented for your information. You will note that this information is approximately two years behind date primarily for legal reasons.

We find the State Health Department and the KSMA staff are very energetic workers.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report of the Committee on Infant and Maternal Mortality as presented. (Motion was seconded and carried.)

**Note: Statistical reports covering maternal deaths in Kentucky for the years 1960, 1961 and 1962 are available at KMA Headquarters on request.*

INDUSTRIAL MEDICINE COMMITTEE, GRADIE ROWNTREE, M.D., LOUISVILLE, CHAIRMAN.

The KSMA Committee on Industrial Medicine met on Wednesday, June 17 at the KSMA Headquarters Office.

It was taken by common consent that the committee approve the following statement consisting of the duties of this committee:

The purpose of this committee shall be to promote higher standards of industrial health, to study and advise the KSMA Board of Trustees on legislation to improve industrial safety and minimize occupational diseases, and to advise and cooperate with industries and companies who request counsel on organizing or re-organizing their company health program.

During a discussion of the committee's duties, the members felt that this included liaison with county medical society industrial health committees, liaison with insurance companies, and liaison with the Kentucky Workmen's Compensation Board. It is also our opinion that we should serve as Industrial Medical Consultants to companies and industries requesting assistance in this field. In the field of legislation, we plan to secure copies of current Kentucky Workmen's Compensation Law and propose additional legislation should we find a need existing. Your committee recommends that the county medical societies should consider organizing committees on Industrial Medicine and we encourage physicians in the Industrial Health field to become members of the Kentucky Industrial Medical Association.

Your Industrial Medicine Committee is planning to meet with representatives of the insurance industry to determine how we can improve the health of our working population and to discuss the relationships in this area existing between insurance carriers and industrial medicine physicians.

The committee also reviewed literature from the AMA which outlined the activities of other medical groups in the occupational health field and will plan to implement any such activities which are felt to be beneficial to Kentucky.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the Industrial Medicine report as presented. (Motion seconded and carried.)

Blood Banks Committee, Ellis A. Fuller, M.D., Louisville, Chairman.

This committee has not met in the past year and has not had any specific material referred to it.

COUNCIL ACTION: It is recommended that the report of the Blood Banks Committee be accepted as presented. The Council would like to bring to your attention the following policy statement on Blood Banks submitted by the AMA Board of Trustees and approved by the AMA House of Delegates and recommends that this policy be put into effect in Kentucky.

"In recent years there has been a dramatic growth of blood banking facilities in the United States. The procurement of human blood and

its transfusion to patients are medical procedures which require the direction and supervision of a physician. The ultimate objective of these procedures is the welface of persons who require blood or blood derivatives. The medical profession has primary responsibility for the care and treatment of patients and, therefore, has a paramount interest in evaluating facilities and procedures for blood procurement, storage and use. This responsibility can best be discharged by medical societies at the local level.

"The American Medical Association's Committee on Blood believes that component and constituent medical societies should be informed of proposed and existing blood banking services within the community and should offer guidance to them. In the opinion of the Committee, it is highly essential that the organization of new blood banking programs and the modification of existing ones should have, in the interest of public health and safety, *the approval of the county or district medical society and therefore should be coordinated with existing approved blood banking facilities, that since a blood bank can well be considered a medical facility, the over-all director—the top authority in the blood bank—should be a doctor of medicine.*"

Recommendations, KMA Board of Trustees

This report was reviewed by the Board of Trustees on August 5, 1964.

BOARD ACTION: Approved with the exception of the wording on page 17 of the council action on the Blood Banks Committee which reads—". . . that since a blood bank can well be considered a medical facility, the over-all director—the top authority in the blood bank—should be a doctor of medicine," be changed to eliminate the word "should," and the section of the report referrable to the Tuberculin testing of schools be not approved with the recommendation that this problem be left to the individual counties.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 moves the adoption of the Blood Banks Committee report as presented, including the Board action as listed on page 18 in which the elimination of the word, "should" is important. (The motion was seconded and carried.)

Tuberculosis Committee, J. Ray Bryant, M.D., Louisville, Chairman.

The Tuberculosis Committee met once during this past year on Thursday, April 16 and had as our guest Mr. Thomas Summers of the Kentucky Tuberculosis Association. Mr. Summers discussed with the committee a proposed Tuberculin Testing Program which is planned to be a joint effort of state and local health departments, the State Department of Education, the State Tuberculosis Hospital Commission, the Kentucky State Medical Association, the Kentucky Tuberculosis Association, and the medical schools of the University of Kentucky and the University of Louisville.

The purpose of the program would be to:

A. Eliminate TB from schools;
B. Find heretofore unknown cases of TB by interviewing "contacts" of the students who have positive reactions to the test;
C. Demonstrate the practicability of skin testing; and
D. Emphasize that TB is still a major health problem.

Mr. Summers stated that the cost of the project would be born by the TB Control Division of the State Health Department and possibly some funds will be made available by the Kentucky TB Association.

Your committee recommends that the Kentucky State Medical Association go on record endorsing the Tuberculin Testing Program in Kentucky schools. The following certification of Kentucky schools requirements for Tuberculin Testing Programs is presented for your information.

CERTIFICATION OF KENTUCKY SCHOOLS REQUIREMENTS FOR TUBERCULIN TESTING PROGRAM

Class A Certificate:

(1) 95-100 PERCENT of all the PUPILS MUST BE TUBERCULIN TESTED unless known to be reactors to tuberculin. All reactors must be referred to the family physician for follow-up with X-ray and/or other diagnostic work if necessary. Reactors should be reported to local and state health departments. Reactors from previous surveys with small or doubtful reactions (indurations of 5 to 9 m.m. inclusive) should be re-tested.

(2) 100 PERCENT of the SCHOOL PERSONNEL MUST BE TUBERCULIN TESTED unless known to be reactors. All reactors must be X-rayed. If for religious or other legitimate reasons the tuberculin test is refused, the X-ray will be mandatory. Reactors should be reported to local and state health departments. School personnel includes administrators, teachers, janitors, bus drivers, cooks, clerical help, and so forth, plus all part-time employees.

(3) All persons whose X-rays show shadows, which might be caused by tuberculosis, must be referred to their family physician for further study. All results of testing and X-rays should be reported to the family physician in order to stimulate search for the source of infection. If there is no family physician, follow-up may be carried on by local chest clinics, out-patient services of the tuberculosis hospitals, public health departments, or welfare departments.

(4) An educational program must be conducted prior to a tuberculin testing program.

(5) all reactors with indurations of 5 to 9 m.m. should be re-tested within 60 days. All reactors of 10 m.m and over should be X-rayed within 60 days. Special attention should be given youngsters at the beginning and during puberty.

(6) If a pupil or member of the school personnel has received the tuberculin test or chest X-ray shortly before the survey is conducted, a report of such test or X-ray from an accredited source will be accepted and counted in the percentage checked.

(7) The INTRADERMAL TEST IS PREFERRED, although other methods may be employed in accordance to the skill of the professional personnel performing the test. Intermediate strength of PPD is recommended for use. The patch test is not acceptable for school certification.

(8) Annual FOLLOW-UP of the FAMILY MEMBERS and other CLOSE CONTACTS of the reactors is urged. It is especially important among the contacts of children in lower grades, although the contacts of all converters should be carefully screened.

(9) A histoplasmosis skin test be given at the same time the tuberculin test is given, if feasible, in which case a statement denoting that both tests were given will be included in the certificate.

Class B Certificate:

Requirements are exactly the same as for Class A, except that only 85 to 95 percent of the pupils must be tuberculin tested.

COUNCIL ACTION: It is recommended that the report of the TB Committee be accepted as presented with the provision that the Kentucky Tuberculosis Association go to the local medical society for approval before instituting this program in the schools. This reverses the recommendation stated in the original presentation wherein the school initiates the action of securing local medical society approval. If in the state of Kentucky in the near future, there is an appreciable increase in the incidence of Tuberculosis,

the Council recommends that legislation be initiated to require TB testing in school children similar to the Immunization Law now in effect.

Recommendations, Reference Committee No. 4

Mr. Speaker, Reference Committee No. 4 agrees with the Board action as listed on Page 18 in which it states that Tuberculin Testing of students be not approved, but this problem should be left to the individual County Society. Much discussion was necessary for this Committee report. The Tuberculin Skin Testing is commendable, but numerous problems are involved, including financial problems, treatment of those who are found to be positive and the principle that it is difficult for many county societies to carry out a program approved by the State. A Histoplasmosis Skin Test would be very useful in Kentucky. Further study of this problem is recommended by the Tuberculosis Committee. Mr. Speaker, Reference Committee No. 4 moves the adoption of the Report of the Tuberculosis Committee as amended by the Council and endorsed by the Board of Trustees.

After discussion, Richard E. Mardis, M.D., of Jefferson County, offered the following substitute motion which was seconded: The report of the Tuberculosis Committee be approved with the exception that the approval of the local county societies be obtained before any program is put into effect in that county. The substitute motion was passed by the House of Delegates.

As chairman of the Council on Allied Professions and Related Groups, I would like to express my appreciation to the members of the Council and to the committee members who served under the Council.

COUNCIL ON ALLIED PROFESSIONS AND RELATED GROUPS
J. Ray Bryant, M.D., Louisville
Ellis A. Fuller, M.D., Louisville
William K. Massie, M.D., Lexington
Gradie R. Rowntree, M.D., Louisville
Melvin J. Weber, M.D., Ludlow
W. Donald Janney, M.D., Covington, Chairman

Recommendations, Reference Committee No. 4

In the view of the subjects presented to our Committee, it appeared that occasionally there was overlapping of the same functions which may be organized to reduce the number of total committees. Specifically, the Industrial Medicine and Physical Rehabilitation Committees have similar problems and may be combined.

Mr. Speaker, Reference Committee No. 4 moves the adoption of the report on the Council on Allied Professions and Related Groups as a whole as amended. (Motion seconded; carried.)

The Chairman of Reference Committee No. 4 wishes to thank all the members of the Committee and the secretary, Miss Linda Powell, for their splendid cooperation.

REFERENCE COMMITTEE No. 4
Paul H. Klingenberg, M.D., Covington, Chairman
William E. Becknell, M.D., Manchester
Andrew M. Moore, M.D., Lexington
Paul J. Sides, M.D., Lancaster
B. H. Warren, M.D., Owensboro

REFERENCE COMMITTEE NO. 5 †

David W. Kinnaird, M.D., Chairman
Reports on Medical Service

† *See note (†) bottom of column one, page 962.*

The following reports and resolutions were considered by this reference committee:
14. Report of the Council on Medical Services
23. Report of the Board of Directors, Kentucky Physicians' Mutual, Inc.
24. Report of the Board of Trustees, Rural Kentucky Medical Scholarship Fund
32. Report of the Advisory Committee to Selective Service
27. Report of the Technical Advisory Committee on Indigent Medical Care
34. Report of the Representative, Kentucky Mental Health Planning Commission
Resolution A
Resolution F

Report of the Council on Medical Services

PREFACE

Procedures for reports of councils and standing committees of KSMA to the House of Delegates are provided for under Chapter VII, Section 4 of the By-laws, which reads in part:

". . . Each standing committee and council shall report annually, at least six weeks prior to the Annul Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted without alteration or amendment to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. . ."

The material in this report of the Council on Medical Services is presented in the following order:

1. *Actions and recommendations by the Council which it undertook on its own initiative.*
2. *Reports of the committees of this Council with the Council recommendations following each committee report.*
3. *Recommendations by the KSMA Board of Trustees on the overall contents at the conclusion of the report.*

* * * *

The Council on Medical Services has met twice during this year, March 5 and July 2. A third meeting is scheduled for July 30 and a report of this meeting will be added as an addendum to this final report.

At its first meeting, the Council members reviewed Resolution J on the Kentucky Penal and Parole Systems Report approved by the 1963 KSMA House of Delegates. This resolution dealt with recommending the adoption of the medical services improvements called for in the report. A copy of the resolution was sent to the Governor and the Commissioner of Corrections and representatives of the Council are planning to meet with the Commissioner to further our assistance in seeing these recommendations adopted. Also at its first meeting, the Council discussed the activities and plans for activities of the various committees serving under the Council and approved a statement of duties of the committees which will become a part of the policy of KSMA. The committees serving under the Council are: Insurance Committee, Medical Discipline Committee, Mental Health Committee, Sub-Committee on Alcoholism, Advisory Commission to Blue Shield, Advisory Committee to Blue Cross, Physicians' Placement and Membership Committee, Federal Medical Services Committee, Medicare Review Committee, and Committee on Aging.

For consideration at its second meeting, the Council had been requested by the Board of Trustees to obtain all available information on the medical programs which are a part of or related to "Appalachia," a special project for comprehensive maternity and infant care to selected high risk women and infants, and other government sponsored programs of medical care.

A special workshop meeting on "Appalachia" was held on May 28 with representatives of this Association, State Department of Health and other interested individuals (It is noted by the Council that there is no Appalachia medical care program in existence as

such at the present time). On July 2, a report of this meeting was presented to the Council members and a detailed discussion on these various health care programs was held. Your Council feels that they still do not have sufficient information to recommend any specific KSMA policy and as mentioned earlier in this report, has called a special meeting of the Council members and invited guests to study further the problems referred to it by the Board.

However, the Council feels that this association should be informed on any and all medical care programs planned for the state of Kentucky and makes the following recommendations:

1. We recommend to the KSMA Board of Trustees that the Committee on Public Health be requested to meet with the Commissioner of Health periodically to review health care programs and that other appropriate KSMA committees meet with the directors of other health agencies in state government health care programs as a means of the association's membership being better informed for cooperative purposes to the programs.

2. We recommend to the KSMA Board of Trustees that they request the Commissioner of Health to keep as well informed as possible with regard to various health programs across the state and transfer that information by way of the Board of Health to the medical profession in general so that the members of the medical profession may be informed through the Journal of KSMA of these programs and activities.

The following reports of the committees serving under the Council are herewith submitted.

Recommendations, Reference Committee No. 5

The Report of the Council on Medical Services summarized the problems relating to the coordination of various health agencies of state government and made recommendations that would permit appropriate KSMA committee liaison with these health agencies as well as encourage the Commissioner of Health to keep the KSMA informed as to various health programs.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion was seconded and carried.)

ADDENDUM TO THE REPORT OF THE COUNCIL ON MEDICAL SERVICES

The Council on Medical Services held its third meeting of the year on July 30. This was a special called meeting to discuss various medical care programs being conducted in Kentucky. The Board of Trustees has requested that this Council become knowledgeable of medical care programs which are a part of or related to "Appalachia." Invited guests attending the meeting included C. Fred Blankenship, M.D., University of Louisville School of Medicine, Stephen G. Edelstein, M.D., State Department of Health, Irving Kanner, M.D., Fayette County Medical Society, Andrew M. Moore, M.D., President, Fayette County Medical Society, Douglas E. Scott, M.D., Chairman of the KSMA Board of Trustees, and Russell E. Teague, M.D., State Commissioner of Health.

A general discussion was held on the fragmentation of health services and how this appears to be a problem in that various state agencies conduct similar health programs and cooperation is not of maximum efficiency. These programs come from various state departments such as the Department of Mental Health, the Department of Health, the TB Hospital Commission, the Commission for Handicapped Children, etc. It was taken by common consent that the council recommends to the Board of Trustees that the Board request the proper committee or committees to study the problem of coordinating the various health agencies now existing through the various state departments and that the committee report back with its recommendations to the Board of Trustees.

The Council goes on record as having received a report on a project to study causes of accidents in selected Eastern Kentucky counties and approves this program as being conducted. We recommend that the findings and conclusions be made available to the Kentucky State Medical Association and other interested parties such as industry.

The Council also received a report concerning the activities of a special multi-phase health screening project in 18 Eastern Kentucky counties. The report was presented by Russell Teague, M.D., State Commissioner of Health, and Stephen Edelstein, M.D., who is in charge of the project. The Council recommends that this study continue to be done only with the approval of the county medical society concerned, and that the cases discovered continue to be referred to the private physicians. The Council feels that the existence of poor follow-up care of the health problems that this screening program has uncovered is in large part due to a lack of health education which in turn is a part of inadequate general education for much of this population.

A special project for "Maternal and Infant Care to Selected High-Risk Women and Infants in Fayette County to Prevent Mental Retardation" was considered by the Council on Medical Services. It is evident that the proposal as originally given to the Fayette County group was not acceptable to this group for numerous reasons and a special committee of the county society is in the process of attempting to develop a more acceptable method of dealing with this problem. As a matter of establishing a policy, the Council on Medical Services recommends to the Board of Trustees that the Council approves the policy that physicians should continue to give of their services for the care of the indigent as they have done in the past and in those cases where tax funds are available for payment of physicians' fees and the care of the indigent, physicians should be willing to accept a level of payment below the fees that would normally be charged to their private patients.

At the time this report is written, the Council does not know what action the Fayette County Medical Society will take in regard to adopting a plan for Comprehensive Maternal and Infant Care of Medically Indigent Patients.

Following a general discussion on the subject of Infant and Maternal Care which was presented by the Commissioner of Health, the Council recommends that either a committee for the study of Infant and Maternal Care be created or that these duties be added to a committee now in existence. The Council further recommends, at the request of the Commissioner of Health, that closer liaison be maintained between a committee assigned such duties and the State Department of Health.

The Council also discussed the present status of the Federal Administration's proposed Appalachia Program and has nothing specific to report on this matter at the present time. In reality there are two separate bills, one on Appalachia and an Anti-poverty Bill. There are no known medical implications in the Appalachia Bill; and although there might be some medical implications in the Anti-poverty Bill, no specifics are presently known.

Recommendations, Reference Committee No. 5

The recommendation for a review committee for the study of Infant and Maternal care to be created or assumed by a committee now in existence is felt to be a worthwhile recommendation.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded.) Irving Kanner, M.D. of Fayette County then offered the following amendment, which was seconded: It is the sense of the House of Delegates that it disapprove that part of the addendum to the Report of the Council on Medical Services which reads on page 18 of the report: . . . "and in those cases where tax funds

are available for payment of physicians' fees and the care of the indigent, physicians should be willing to accept a level of payment below the fees that would normally be charged to their private patients".

The vote on the amendment carried.

Insurance Committee, J. A. Bishop, M.D., Louisville, Chairman

The Insurance Committee has not met this year since no matters have been referred to this committee for action. Your chairman has enjoyed working with the Insurance Committee in the past and hopes the committee continues to function as a member of the Council on Medical Services.

Recommendations, Reference Committee No. 5

The Insurance Committee report was reviewed and is recommended for acceptance.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Mental Health Committee, Frank M. Gaines, M.D., Louisville, Chairman

The Mental Health Committee had a series of four major meetings and a large number of sub-committee meetings primarily to plan the Congress on Mental Health which took place on May 14, 1964 in Louisville, Kentucky. This meeting, attended by 150 participants both physicians and non-physicians, was organized to present the general developments in the mental health field and encouraged physician participation. The Committee is currently making efforts to evaluate the Conference in order to make further plans for next year.

The committee wishes to thank the Board of Trustees for their financial and moral backing in its activities during the year.

Recommendations, Reference Committee No. 5

The report of the activities of the Mental Health Committee and the promotion of the successful Congress on Mental Health has been reviewed. Its acceptance is recommended by this reference committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Sub-Committee on Alcoholism, John C. Keeley, M.D., Owensboro, Chairman

The Kentucky State Medical Association's Sub-Committee on Alcoholism met once this year on June 11. This was an organizational meeting in that it is our Association's first formal committee on Alcoholism and this was our first meeting. This is a subcommittee of the Mental Health Committee and serves under the Council on Medical Services.

At our meeting, we reviewed the committee's duties as approved by the council and an Eighteen Point Program on Alcoholism published by the AMA Committee on Alcoholism.

It was taken by common consent that we should limit ourselves to collecting and evaluating information, serve as a clearing house, and furnish information to those seeking it on request. It was felt that our first move should be to find out what the state's problem is and what current resources we have available.

In addition to evaluating the alcoholism problem in Kentucky, we will also review the accomplishments by other states in this field.

I would like to take this opportunity to thank the other members of this committee for their participation this past year.

Recommendations, Reference Committee No. 5

The Subcommittee on Alcoholism has begun an exhaustive study of this problem. This reference committee recommends the acceptance of this study by the House of Delegates.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Advisory Commission to Blue Shield, W. Vinson Pierce, M.D., Covington, Chairman

The KSMA Advisory Commission to Blue Shield met at the KSMA Headquarters Office on April 30, 1964. This was the only meeting held by the Commission during the year.

Part of the meeting was devoted to a resume of the recommendations which have been made to the Kentucky Blue Shield Plan (Kentucky Physicians' Mutual, Inc.) in recent years, and to the actions taken by the Blue Shield Plan in regard to implementing these recommendations. It was pointed out that in every instance thus far, the recommendations of the Advisory Commission have been accepted by the Board of Directors of Kentucky Physicians' Mutual, Inc., and implemented by the Plan.

A report was made to the Advisory Commission by the staff of Kentucky Physicians' Mutual concerning enrollment and activities of the Plan. The continuing growth of the plan in enrollment and in extent of coverage was noted; and it was especially gratifying to note that more and more of our elderly people are continuing their coverage as they retire from groups which are covered by Blue Shield.

Three recent actions of the House of Delegates of the KSMA were referred to the Advisory Commission to Blue Shield for consideration and recommendations.

One of these was Resolution F, introduced by the Campbell-Kenton County Medical Society in the House of Delegates last September, and passed by the House. This Resolution read: "Resolved, that the KSMA recommends to the Blue Plans that any and all policies issued make a clear distinction between hospital and physician services, with Blue Shield paying the physician services."

Members of the Blue Shield staff pointed out that this is being accomplished already; the only area for misunderstanding being that this is not clearly printed on certificates now being issued.

The Advisory Commission recommended to Blue Shield that on new certificates to be issued, the distinction regarding services be more clearly defined.

In regard to the Harlan County Resolution concerning the payment of physiatrists for services rendered in hospitals, it was stated that this is being done routinely by Kentucky Blue Cross-Blue Shield.

In compliance with the recommendation made by Doctor Dave Cox in his Presidential Report, and accepted by the House of Delegates, the Advisory Commission voted to recommend to the Board of Directors of Kentucky Physicians' Mutual, Inc., that in the future, the term of office of a director shall consist of no more than three consecutive terms of three years each, to become effective at the next election (but not to be retroactive).

The staff of Kentucky Blue Shield-Blue Cross reported to the Commission concerning new electronic equipment which has recently been installed in the Blue Shield-Blue Cross Building. The Advisory Commission requested that the staff of Blue Shield think specifically as to how this new equipment could be utilized to spot weaknesses in the operation of the Plan, and promised the help and support of the commission in trying to improve the areas of weakness.

The Advisory Commission to Blue Shield wishes to express its sincere thanks to the Board of Directors and to the staff of Kentucky Physicians' Mutual, Inc., for their cooperation and for their consideration of the various recommendations made by the Commission in the Past.

To Mr. J. P. Sanford and his staff, the Commission wishes to express its appreciation for the invaluable help rendered in carrying out the work of the Commission.

We also wish to thank the House of Delegates of the KSMA, the Board of Trustees, and the President of the Association for their support and confidence during the past year.

Recommendations, Reference Committee No. 5

The complete report of the Advisory Commission to Blue Shield has been reviewed and this committee has faithfully implemented the recommendations made by the House of Delegates of KSMA. Therefore, the members of this reference committee recommend the acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Advisory Committee to Blue Cross, Sam Overstreet, M.D., Louisville, Chairman

Your Advisory Committee to Blue Cross consists of some 17 physicians from across the state. We meet monthly, usually four members at a time, at the Blue Cross-Blue Shield Building in Louisville to review questionable or controversial claims that have been submitted to the Blue Cross by physicians. Primarily, this is an educational procedure since most questionable claims are merely a misunderstanding on the doctor's part. Our entire committee has met once this year.

Recommendations, Reference Committee No. 5

The report of the Advisory Committee to Blue Cross has been reviewed and this reference committee recommends the acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Physicians' Placement and Membership Committee, Claude E. Cummins, Jr., M.D., Maysville, Chairman

The Placement and Membership Committee met on June 25, 1964, and five of the seven members were present. Duties of the Committee, as approved by the Council on Medical Services and the Board of Trustees, were read, and members were informed that these duties would become a part of Kentucky State Medical Association's Bylaws under the heading of this Committee.

It was interesting to note that our Association's membership reached an all-time high last year. Active members numbered 2,183 on December 31, 1963. To this we can add 102 emeritus for a grand total of 2,285 members. Membership in AMA on December 31 was 1,988. As of May 31, 1964, we had 37 more KSMA and 32 more AMA members than we had on the same date in 1963.

According to our best estimates, we have about 2,700 physicians in Kentucky. We would like to be more positive about this figure. This Committee in 1963 made a recommendation to the House of Delegates that approval be given for annual registration so we could be more definite as to the number. It was interesting to listen to a tape recording of the 1963 House of Delegates meeting and hear comments made by those who were opposed to annual registration. One opponent said we could get all the information needed from drug detail men. Another said he thought county medical society secretaries provided this information. Although the Commissioner of Public Health said his Department of Licensure could administer a program of annual registration without fee, one physician took the floor and said he renewed his license to practice in California each year. He said the fee had been increased from time to time and now it costs $20 per year.

At our Committee meeting on June 25 we had information showing that California has biennial registration and the fee is $18. We are convinced that county medical societies could provide the number of dues-paying and non-dues-paying members in the counties, but experience has shown that this is not working. Drug detail men are the biggest group requesting the medical directory published by the Division of Licensure. Incidentally, it takes about six months to check the information for the medical directory, which is revised every two years. This could be done in about one month and much more accurately if there were a good system of annual registration. Thiry-five states require physicians to register annually, and another ten require registration biennially.

Other reasons for annual registration are:

1. The Indigent Medical Care Program requires the signature, license number and other information before any reimbursement can be made. On numerous occasions vendor physicians have been delayed payment for their services until such time as this information could be received.
2. Practically all other professions in Kentucky have annual registration of their members.
3. KSMA contracts with the Veterans Administration for Hometown Medical Care and it is not unusual for the Veterans Administration to request information from the Headquarters Office on certain doctors.
4. Seldom a day passes but what the Headquarters Office receives calls from someone asking for such information as the full name of a physician, where and how long has he practiced in the present location, and is he a member of KSMA and AMA.
5. The various specialty organizations frequently contact the office to find the number of specialists and the towns and counties in which they practice.
6. Headquarters Office is often called upon to address envelopes for announcements of doctors. On many occasions, doctors have been critical of the Office when they have a large number of letters returned because they were not given the correct address.
7. The Office gets calls from physicians or lay people from other states asking for leads on physicians who might be practicing in Kentucky.
8. The Alumni Office at U of L depends on the Headquarters Office for much of its information on medical alumni.
9. It is expensive to have letters, journals, and other material returned when sent to the wrong address. It is also embarrassing to the Headquarters Office. It makes it appear that due care has not been exercised in keeping the records current.

Our Committee feels that our Medical Association and the Division of Licensure should not have to depend upon newspaper clippings as their best source of information on doctors entering practice for the first time, changing locations, and for information on those who have died. For the reasons mentioned above and many others, our Committee strongly recommends that our Kentucky State Medical Association House of Delegates authorize the Commissioner of Health to establish a regulation in his Department making it compulsory for all physicians to register annually.

Recommendations, Reference Committee No. 5

The reference committee discussed in detail the portion of the report dealing with annual physician licensure registration, and in spite of some valid objections, it is the recommendation of this committee that this annual physician licensure registration proposal be endorsed by the KSMA House of Delegates and that the Commissioner of Health establish the mechanics of the annual registration as outlined in the report.

After discussion, Martin Wilson, M.D., Warren County, proposed an amendment that the report dealing with annual physician licensure registration in the report of the Council on Medical Service be adopted with the exception of the sentence on page twelve which reads: "For the reasons mentioned above and many others, our Kentucky State Medical Association House of Delegates authorize the Commissioner of Health to establish a regulation in his Department making it compulsory for all physicians to register annually." The motion was seconded and the amendment carried.

Report of Physicians' Placement and Membership Committee (Continued)

We reviewed the Negro situation relative to membership in KMA. Seven counties have Negro physicians and four of this number accept them as members. It is understood that two other counties will take them as members if such requests are made. Negro doctors have hospital staff privileges in six of the counties. Since this subject does not present an acute problem in Kentucky, and in view of the fact that it is brought up as an issue each year at the AMA Annual Meeting, our Committee urges each county medical society having Negro doctors to accept them as members in the county medical society. This, of course, is with the understanding that they have completed training in a class A medical school, finished an approved internship, passed the state medical board examination, and are ethical and eligible in every respect.

The Placement part of our Committee's responsibility has been most effective during the past year. A large number of trained doctors have gotten information through our Placement Service and have located throughout the state. This Service definitely makes for a better distribution of doctors because they learn of locations they might not hear about otherwise. We particularly want to commend the work of those responsible for the Rural Kentucky Medical Scholarship Program for their efforts in placing doctors in needed areas. The 122 Scholarship recipients now practicing in 75 different counties have certainly been a credit to our KMA.

Recommendations, Reference Committee No. 5

The subject of Hospital staff privileges of Negro doctors in our county societies has been well reviewed, and it is our recommendation that each county medical society accept Negro physicians as equal members as proposed by the Physician Placement and Membership Committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

In addition, we recommend that the Bylaws be amended to Section 4, Chapter XI be eliminated in so much as this section refers to the issuance of charters to organizations of Negro physicians outside of the county medical societies.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Mr. Speaker, I move the adoption and implementation of this section of the report as modified. (Motion seconded and carried.)

Federal Medical Services Committee, L. F. Beasley, M.D., Franklin, Chairman

The Federal Medical Services Committee has been in frequent communication with the Federal Government concerning the Federal Services contract (the true medicare program for dependents of active armed forces personnel).

A new contract for 1964-1965 identical with the 1963-1964 contract was signed with the Federal Government. There have been no complaints. In the absence of specific business, no meeting has been held this year.

Recommendations, Reference Committee No. 5

This report was reviewed and is recommended for acceptance.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Medicare Review Committee, Henry Collier, M.D., Louisville, Chairman

The Medicare Review Committee acts on special cases submitted under the true Medicare Program (Medical Care for Dependents of Active Armed Forces Personnel). Normally this committee meets semi-annually with representatives of Blue Cross-Blue Shield and representatives of the Office of Dependents Medical Care, Denver, Colorado.

During the calendar year 1963, the number of claims paid under this program increased while the special cases reported to the committee decreased approximately 34%. There were, during this period, 5,275 claims paid and 97 cases reviewed by members of the committee for our recommendation.

We have continued our policy of distributing claims among the committee members according to their specialty in order that the claims needing review can be considered by the physician in the proper specialty.

Recommendations, Reference Committee No. 5

The activities of the Medicare Review Committee have been reviewed and this report is recommended for approval.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded and carried.)

Committee on Aging, Earl P. Oliver, M.D., Scottsville, Chairman

The KSMA Committee on Aging met once during the Associational year, on May 12, 1964. The committee members approved a statement outlining the duties of the committee and held a general discussion on the Kerr-Mills Program in Kentucky. The committee feels that there is a need for a provision in the Kerr-Mills Program to cover those recipients who have a protracted illness which requires more than ten days hospitalization.

The chairman had the pleasure of representing KSMA and the Aging Committee at a meeting in Atlanta this year on the Institute on Facilities for Long-Term Illnesses. A report on this meeting has been submitted to the chairman of the Council on Medical Services.

The Committee also discussed this year the problem of classifying and upgrading nursing homes. The committee recommends to the KSMA Board of Trustees through the Council on Medical Services that the KSMA Journal carry requirements for accreditation of nursing homes and applications for approval procedures. It was further recommended that each county society secretary and each hospital chief of staff be sent the following:

(1) Advice on categories of nursing homes;
(2) Where to apply for accreditation; and
(3) That the cost for accreditation visit is $75.00 plus $1.00 per bed.

The KSMA Committee on Aging recommends to the House of Delegates through the Council on Medical Services and the Board of Trustees that:

(a) KSMA continue to give its full support to the AMA's Eight Point Program for the Aging.
(b) The Physicians of Kentucky continue to encourage and assist the Senior Citizens in preventing illnesses, preserving their health, and remaining a part of the main stream of life by remaining useful and participating in the family group and all walks of life as long as possible.
(c) The KSMA members discourage increased federal governmental control over the lives of our older citizens and citizens of all age groups.
(d) The KSMA encourage the upgrading and improvement of the nursing home facilities in Kentucky, and strive to have a high-grade level of nursing care and medical care rendered in these facilities; and further that the KSMA members stimulate the building of the necessary number of acceptable nursing home facilities in Kentucky.
(e) The KSMA go on record endorsing the accreditation of nursing homes by the National Council for the Accreditation of Nursing Homes, but submit a request to the Council that the standards not be made unattainable because of a lack of qualified personnel to staff the nursing homes.

COUNCIL ACTION: It is recommended that the report of the Aging Committee be accepted as presented with one exception. The Council recommends that the words "on request" be added to the last sentence of the third paragraph making it read: "It was further recommended that each county society secretary and each hospital chief of staff be sent on request the following:". In reference to the first paragraph, it is the understanding of the members of this Council that some provision is made for such patients in dire need.

The chairman of the Council on Medical Services would like to express his sincere appreciation to the committee chairmen, the committee members, and to those who have served on the Council on Medical Services.

COUNCIL ON MEDICAL SERVICES
John A. Bishop, M.D., Jeffersontown
Frank M. Gaines, M.D., Louisville
Earl P. Oliver, M.D., Scottsville
Sam A. Overstreet, M.D., Louisville
Robert E. Pennington, M.D., London
Claude C. Waldrop, M.D., Williamstown
W. Vinson Pierce, M.D., Covington, Chairman

Recommendations, Reference Committee No. 5

The report of the Committee on Aging was found to have many important suggestions for dissemination of information on accreditation of nursing homes. In addition, the committee summarized the interest and efforts of Kentucky physicians to assist the older citizens while at the same time discouraging increased federal government control of these senior members of our society. The plea to the National Council for Accreditation of Nursing Homes not to make the standards for acceptance unobtainable because of certain personnel requirements, was noted and thought to be of importance.

The entire report of the Committee on Aging is recommended for acceptance.

Mr. Speaker, I move the adoption and implementation of this section of the report. (The motion was seconded and carried.)

Report of the Board of Directors, Kentucky Physicians' Mutual, Inc.

The Board of Directors of Kentucky Physicians Mutual, Inc. respectfully presents its annual report to the Kentucky State Medical Association. It reflects the fifteenth year of operation and service to the people of Kentucky.

As of July 31, 1964, 848,469 people were members of the Plan, an increase of 37,808 over the membership one year ago. In addition, 41,396 persons are now also enrolled in our Extended Benefits program and 9,696 persons in the Major Medical coverage. During the 12-month period ending June 30, 1964, $9,257,865.18 was paid to physicians. This is an increase of $908,840.29 over the previous 12-month period. Calendar year 1964 payments to physicians will approximate 10 million dollars.

The cost of operation for the year ending June 30, 1964 was 10.6% of income. We continue to rank favorably with other Blue Shield Plans with respect to operating cost in that only 9 of the 71 Blue Shield Plans operated at less administrative cost per member than the Kentucky Plan.

During the year the new group rates based on experience have been instituted, and the downward trend in financial experience has been corrected.

The standard coverages are now no longer offered, and all new subscribers are being enrolled on the more equitable "C" and "D" schedules. Also, an all-out effort is being made to get the old standard subscribers to switch to the better coverage.

Blue Shield, being a mutual insurance company, continued to be harassed by municipalities seeking to collect premium taxes. A number of settlements were made. However, through the leadership of the legislative council of the State Medical Association we were able to support passage of legislation when passed exempting hospital, dental, medical, and/or surgical, domestic, mutual insurers from these levies.

During the year the Kentucky State Medical Association formed an Insurance Review Board, which will be of great assistance in fostering the voluntary prepayment system.

At its January 27, 1964 meeting your Board voted to cooperate with any County Society that desired to institute a pay-all plan. First county to take advantage of this is Perry County.

In closing I want to express my appreciation to all members of the profession who, by their cooperation, have made another successful year for the Plan. I would particularly like to thank those who were so diligent in obtaining the worthwhile legislation vital to our continued progress. My deep appreciation is also expressed to members of the Board, fellow officers and staff for making this another successful year.

William H. Cartmell, M.D.
President

Addendum to the Report of the Kentucky Physicians' Mutual, Inc.

It will be recalled by you that David Cox, M.D., in his Presidential Report to the House of Delegates of the KSMA in 1963, pointed out that members of the Board of Trustees of the KSMA were limited to two three-year terms, and that members of the Board of Trustees of the AMA were limited to three three-year terms. It was Doctor Cox's recommendation that his proposal should not begin to operate until the beginning of 1964, and that all present members of the Board of Directors would be eligible to serve the full three terms of three years each.

This proposal of Doctor Cox was approved by the Reference Committee and adopted by the House of Delegates. It was referred to the Advisory Commission for implementation, and the Advisory Commission in turn voted to recommend that the Board of Directors of KPM adopt this as their policy in the future.

At the meeting of the Board of Directors of KPM, held on September 27, 1964, the Board voted to approve the policy of limiting the terms of its Directors (not to be retroactive) to three terms of three years each; and a special committee was appointed to present this recommendation to the meeting of the members to be held later in this year; since the Directors are elected by the members of KPM at their annual meeting.

It was the feeling of the Board of Directors that this new policy should apply to the physician members of the Board, but not necessarily to the lay members.

Recommendations, Reference Committee No. 5

The report of the Board of Directors, Kentucky Physicians' Mutual, Inc., as well as the addendum to the report has been studied and it is found to be complete and adequately signifies the continuing excellent operation and services to the people of this state. The committee therefore recommends the acceptance of the report.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Board of Trustees, Rural Kentucky Medical Scholarship Fund

Our Rural Kentucky Medical Scholarship Fund is observing its eighteenth birthday this year. The revolving fund which started in 1946 was designed to

help medical students financially and in return they would agree to practice in a qualifying rural area of Kentucky twelve months for each loan received.

Founders of the Scholarship Program put on a fund-solicitation campaign when the Program was initiated, and $168,117.45 in contributions were received.

In 1954 Governor Lawrence Weatherby allocated $10,000.00 to the Fund from the Commonwealth for the last biennium of his four-year term. Governor A. B. Chandler followed with $100,000.00 during his four-year term (1956-59). Governor Bert T. Combs budgeted $100,000.00 during his term and, in addition, took $15,000.00 from his emergency fund. This makes a total of $225,000.00 received from the Commonwealth. A grand total of $393,117.45 has been placed in the revolving fund from both private and Commonwealth donations as of July 1, 1964.

Governor Edward (Ned) Breathitt is allocating $60,000.00 for the first biennium of his term, and $30,000.00 of this amount is expected to be available during the latter part of July.

A total of 741 loans have been granted to 258 different students for an average of 2.87 loans per recipient. The average amount of each loan has been $889.40 with a total of $659,046.00 being lent since the revolving fund started.

After checking with The Louisville Trust Company, fiscal agent for the Fund, we find that on June 5, 1964, outstanding notes signed by the recipients amounted to $380,035.93. It is anticipated that money coming in from due notes and from the Commonwealth plus cash on hand will be sufficient to permit us to make 46 loans of $1300.00 each this year for a total of $59,800.00. The Trustees of the Fund favor larger loans to fewer students each year in order that recipients will feel that the Fund is a major source of the income which helped them get through medical school. This will naturally cause them to have more concern and respect for the Program.

Interest collected from recipients as their notes are repaid just about takes care of the Program's administrative cost. When recipients locate in any of the ten most critical counties in need of physicians and loans are cancelled for each twelve months of practice given, this amount comes out of the principal portion of the Fund if there is not a sufficient amount in interest money. Loans will be cancelled for four recipients this year because they are practicing in critical counties.

The Board has its annual meeting in May of each year. At this time first-loan applicants are interviewed and those qualifying are approved for loans. Also, second-, third-, and fourth-loan applicants are approved, but personal interviews for this group are not required. The critical counties are reviewed, and a decision is made on the ten most critical counties for the coming year. Counties on the list for July, 1964 to July, 1965 are Martin, Owsley, Magoffin, Elliott, Leslie, Knott, Wolfe, Breathitt, Powell, and Lee.

The Executive Committee of the Board of Trustees meets annually in August. During this meeting, more time is given to individual requests and problems, and a more comprehensive review is made of the entire program.

A Postgraduate Committee composed of three members meets as need indicates. This Committee approves or disapproves each recipient's request to take a residency. This year the Trustees approved postgraduate training in pediatrics, internal medicine, family practice, general practice, and ophthalmology. These will be added to the original list of pathology, radiology, anesthiology, and ENT. The Postgraduate Committee presently approves one recipient per year to take a residency, and the Committee decides which of the approved specialties presents the greatest need in rural areas.

Of the 258 students previously mentioned who received loans, 18 withdrew or were dropped from medical school, 8 were Negroes, 9 were females, and 9 were non-Kentucky residents. Of the non-residents, 3 were from Tennessee, 2 from Indiana, and 1 each from New York, California, Iowa, and Michigan. Because of so many Kentuckians applying for loans, we quit considering the requests of non-residents in 1960.

The 258 recipients of loans attended medical schools as follows: 182—University of Louisville, 31—University of Kentucky, 12—University of Tennessee, 5—Vanderbilt, 5—St. Louis University, 4—Meharry, 3—Tulane, 2—Duke, 2—Emory, 2—Howard, 2—University of Cincinnati, 2—Bowman Gray, and 1 each from Creighton, Temple, Northwestern, Iowa, Wayne, and George Washington University. During the last four years plus this coming year, 31 different students will have attended University of Kentucky while 29 will have attended University of Louisville.

During the 1964-65 school year 51 Scholarship recipients will be attending medical schools as follows: 22—University of Louisville, 26—University of Kentucky, 1—Meharry, 1—Tulane, and 1—University of Tennessee. Twelve will be interning, and eighteen will be meeting their military obligations.

Eighty-four different Kentucky counties have had Rural Scholarship recipients attend medical schools. By number from counties they are as follows: 32—Jefferson; 12—Fayette; 8—Daviess, Floyd, Pike; 6—Whitley, Letcher, Barren; 5—Bell, Calloway, Fulton; 4—Carter, Christian, Franklin, Hardin, Johnson, Kenton, McCracken, McCreary, Madison, Monroe, Nelson, Scott; 3—Clay, Harlan, Hopkins, Marshall, Mercer, Pulaski, Rowan, Todd, Union, Warren; 2—Adair, Allen, Bourbon, Campbell, Casey, Edmonson, Elliott, Grayson, Hancock, Harrison, Henderson, Leslie, Logan, McLean, Marion, Owsley, Powell, Shelby, Washington; 1—Ballard, Boone, Boyd, Boyle, Breckinridge, Bullitt, Caldwell, Carlisle, Clark, Clinton, Crittenden, Cumberland, Estill, Graves, Green, Hardin, Knox, Laurel, Lawrence, Lincoln, Martin, Menifee, Muhlenberg, Ohio, Pendleton, Perry, Rockcastle, Trimble, Wayne, Webster, Wolfe, and Woodford.

Seventy-five different Kentucky counties are now being served by 122 Scholarship recipients. A number of recipients have fulfilled their financial and moral obligations and have moved to other locations. Locations as to number and counties are as follows: 9—Jefferson; 4 — Greenup, Muhlenberg; 3 — Barren, Breckinridge, Hardin, Hopkins, Madison, Monroe, Simpson, Whitley; 2—Boyle, Bullitt, Calloway, Christian, Daviess, Edmonson, Fleming, Grayson, Harrison, Johnson, Larue, McLean, Marshall, Nelson, Owen, Rowan, Shelby; 1—Adair, Anderson, Bath, Boone, Breathitt, Butler, Caldwell, Carlisle, Carroll, Carter, Clark, Clay, Clinton, Crittenden, Cumberland, Floyd, Franklin, Graves, Hancock, Harlan, Hart, Henderson, Jackson, Jessamine, Knott, Laurel, Lee, Leslie, Livingston, Lyon, McCreary, Mason, Meade, Mercer, Montgomery, Nicholas, Pendleton, Pike, Powell, Rockcastle, Russell, Scott, Todd, Trigg, Union, Warren, and Webster.

Locations not approved for recipients to practice are: counties of Campbell, Daviess, Fayette, Jefferson, Kenton, and McCracken, and towns of Ashland, Bowling Green, Frankfort, Henderson, Hopkinsville, Madisonville, Middlesboro, and Richmond. Negro recipients are not restricted as to location; they can practice in any town in Kentucky.

Every member of the Board of Trustees of the Scholarship Fund would like to take this opportunity to thank Governor Breathitt and the 1964 General Assembly for their interest and support in this worthwhile program. We would also like to express sincere appreciation to Doctor Teague for the many contribu-

tions made by him. Lastly, we would like to thank KSMA Headquarters Staff for administering the Program efficiently and effectively.

Rural Kentucky Medical Scholarship Fund
C. C. Howard, M.D., Chairman,
Board of Trustees

Recommendations, Reference Committee No. 5

This continues to be a most satisfactory committee activity and these worthwhile efforts are certainly recommended for approval.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Advisory Committee to Selective Service

There have been no formal meetings of the committee this year but problems arising have been solved by personal or telephone conversations as needed.

Our relationship with Kentucky's Selective Service System at Frankfort has been pleasant and complete cooperation and understanding have been accomplished.

The number of cases requiring reference to our committee for special consideration seems to be diminishing, as a better appreciation of the draft regulations become better understood.

Advisory Committee to Selective Service
James Archer, M.D., Paintsville
Glenn U. Dorroh, M.D., Lexington
Charles B. Billington, M.D., Paducah
O. B. Coomer, D.D.S., Louisville
Sydney G. Dyer, M.D., LaCenter
F. E. Hull, D.V.M., Lexington
Frank Jordan, D.D.S., Louisville
Lula B. McClain, R.N., Louisville
Sam A. Overstreet, M.D., Louisville
Marcus Randall, D.D.S., Louisville
Russell E. Teague, M.D., Frankfort
L. O. Toomey, M.D., Bowling Green
J. Duffy Hancock, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 5

This report has been reviewed and is recommended for adoption.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Technical Advisory Committee on Indigent Medical Care

Our Technical Advisory Committee met on April 9, 1964, and all six members were present. This was the only meeting of this Committee since the last session of the House of Delegates. The Indigent Medical Care Program appears to be operating in a reasonably acceptable manner, and there has been no drastic change in the Program for the last few months.

At the Governor's Advisory Council on Indigent Medical Care meeting on February 19, 1964, reported general irregularities by the vendors group were discussed. It was pointed out that seven (7) irregularities have apparently occurred in the field of physician services. They are as follows:

1. Billing for services *not* rendered.
2. Billing for services to hospital inpatients or outpatients under the guise of home and office visits.
3. Steering patients to specific pharmacies by the use of telephoned prescription orders.
4. Billing patient over and above the Program payment.
5. Substitution of drugs after they have been dispensed by the pharmacist.
6. Presigning prescription blanks and giving them to the pharmacist.
7. Physician allowing someone else to use his signature.

The Council asked each vendor group to study these charges and make a statement or give recommendations for correcting them at the next meeting of the Council. Our Committee approved the following statements and recommendations, which were reported to the Council on June 24, 1964.

ITEM 1 and ITEM 2: These are acts of dishonesty, and we obviously do not condone such acts.

ITEM 3: We do not propose to deny the use of telephones as a means of transmitting prescriptions. We do propose, however, that if this means of communicating is used, the patient should be given the right to the choice as to the pharmacist selected.

ITEM 4: Our Committee feels that if this practice is at all widespread, it must be a result of misunderstanding rather than any willful violation of either the spirit or letter of the Program. We suggest that it be made clear to vendor groups that:

(a) The Program is a service contract rather than an indemnity one.
(b) Acceptance of each patient is on a date basis rather than an illness basis.
(c) There is nothing binding any vendor to accept a patient.
(d) Provisions are available for returning monies collected in event patient or relatives wish to pay the vendors regular charge.

ITEM 5: If a physician substitutes drugs for his own gain, he should be severely censored. In the event the physician should find that he had erroneously prescribed, a substitute would be in order, and the patient and the pharmacist should be cognizant of this fact.

ITEM 6: If the physician presigns prescription blanks and gives them to the pharmacist, he is in essence giving the pharmacist the right to practice medicine. Unequivocally, we are opposed to this type of medical practice.

ITEM 7: We see no reason why anyone should sign the forms for physicians in this Program except in incapacitating illness and death.

In addition to giving our views on the irregularities, the Committee made the following recommendations to the Council. Many of them have been made previously. They are:

1. That extended hospitalization for certain serious medical conditions be made possible on the advice of, and request of, the attending physician and the involved hospital, such requests being subject to review by a local review committee when requested.

2. That the existing Federal and State laws and operating regulations be reviewed to determine whether or not catastrophic illnesses which deplete rapidly the reserves of a non-eligible participant would permit the individual to become eligible if this catastrophic illness reduces his income or resources to an eligible level, subject to some method of review which would determine his length of eligibility.

3. While this Committee feels very strongly that service pertaining to the health needs of our people based on need should continue, we are ready, and we are sure we represent the feeling of other technical advisory committees, to assist in advance in planning any expansions.

4. We wish to recommend again that studies be made to determine the feasibility of entering into a contractual arrangement with Blue Cross-Blue Shield or some other competent insurance carrier referable to the programs of MAA and OAA.

5. With reference to drugs, our Committee wishes to call your attention to three things:

(1) There is some dissatisfaction with the price the Program is paying for certain drugs.
(2) There is some dissatisfaction with having a drug list at all.
(3) There is some dissatisfaction with the use of a

prescription form.

On the basis of these, our Committee recommends:

(1) That a review of the drug prices be made, and

(2) That since we understand that certain states have discontinued the use of drug lists and form prescription blanks, we would ask the Council to investigate the experiences of these states, securing from them experience which may enable us to operate our Program more economically and efficiently, and more satisfactorily to both vendor and recipient.

We think the medical care identification cards which will be issued to public assistant recipients on a monthly basis may solve many problems, inasmuch as they will be issued just prior to the month of eligibility. This new identification card system is to become effective September 1, 1964.

It is evident that our Indigent Medical Care Program is here to stay, and our Committee is of the opinion that physicians should make every reasonable effort to cooperate with the Kerr-Mills approach. This will result in a situation which should satisfy a majority of our congressmen and cause them to feel that a King-Anderson type legislation is unnecessary.

KSMA Technical Advisory Committee
to the Medical Assistance Program
George Estill, M.D., Maysville
Paul F. Maddox, M.D., Campton
Carroll H. Robie, Jr., M.D., Louisville
Charles J. Shipp, M.D., Greenville
Claude C. Waldrop, M.D., Williamstown
Clyde C. Sparks, M.D., Chairman, Ashland

Recommendations, Reference Committee No. 5

The report of the Technical Advisory Committee on Indigent Medical Care was of interest to the undersigned and the recommendations for corrections of irregularities that have occurred in the field of physicians' services were noted and thought to adequately express the feelings of the majority of physicians. The additional recommendation by this committee pertaining to extended hospitalization for serious medical conditions and the inclusion of non-eligible participants with catastropic illnesses which deplete their resources, ought to be worthy of consideration by all concerned.

The other recommendations for study for contractual arrangements with Blue Cross and Blue Shield as well as review of the mechanics of drug distribution seemed to be deserving of investigative study and may provide useful information.

Your attention is called to paragraph 3 under item 7, which we believe can be interpreted as recommending that any expansion of this program be based on needs of the indigent patient for which this program was originally instituted.

This entire report is recommended to the House of Delegates to be approved in its entirety.

Mr. Speaker, I move the adoption and implementation of this section of the report. (The motion was seconded.)

In the discussion that followed M. R. Gilliam, M.D., Fayette County, proposed an amendment that the report of the Technical Advisory Committee on Indigent Care be accepted with the recommendation that the appropriate agency of this Association take steps to eliminate payment of physicians fees under the Kerr-Mills program. This amendment was seconded.

W. Donald Janney, M.D., Kenton County, proposed an amendment to the amendment that the Report of the Reference Committee be adopted except that the Board of Trustees be directed to study the possibility of termination of payment of physicians fees. This received a second. After further discussion, Doctor Janney with the consent of his seconder withdrew his amendment to the amendment.

A motion was made that the amendment of Doctor Gilliam's be tabled. This was seconded and the motion carried.

A vote was then taken on the original motion contained in the report of the reference committee and this motion carried.

Report of the KMA Representative, Kentucky Mental Health Planning Commission

Background

The Mental Health Study Act, passed by the Federal Congress in 1955, directed the Joint Commission of Mental Illness & Health to analyze and evaluate the needs and resources of the mentally ill in the United States, and make recommendations for a national mental health program. An extensive study was then made by experts under the sponsorship of 36 organizations, including the American Medical Association, making up the Commission. This was published in 1961 under the title "Action for Mental Health."

In 1962, the Congress appropriated preliminary planning funds to implement President Kennedy's program to improve the facilities for mental illness and retardation. Kentucky's share was $63,000 for each of two years. During this time, the State is expected to develop a comprehensive long-range mental health program.

In 1963, the Congress allocated $329,000,000 to the states under the Mental Retardation Facilities and Community Mental Health Centers Construction Act. The bulk of this money is for the construction of facilities with the Federal Government matching available state and local funds varying from 1/3 to 2/3 of the cost for approved individual projects. Part I of the Act provides grants for the construction of centers for research on retardation and related aspects of human development, project grants for the construction of university affiliated facilities for the mentally retarded, and grants for the construction of facilities for the mentally retarded, and makes provision for the training of teachers of mentally retarded children. Part III of the Act provides grants for the construction of the community mental health centers. The early versions of the legislation included the provision for financial assistance to underwrite in part the initial staffing of community mental health centers. This provision was eliminated from the Bill which was finally enacted as Public Law 88-164.

Kentucky State Plan

In June, 1963, Governor Bert Combs appointed a Mental Health Planning Commission. Doctor Frank M. Gaines, Jr., was appointed to this Commission as a representative of the Kentucky State Medical Association. The Commission was enlarged in May, 1964, by Governor Breathitt. Meanwhile, a staff under the direction of Mr. Stanley Blostein, serving as a Division of the Kentucky State Department of Mental Health, has begun preliminary investigation of the resources and needs in the mental health field in Kentucky. This has involved several staff studies including an extensive survey of private psychiatric facilities. Information has also been gathered from the Kentucky Manpower Commission, which has been making an independent study of the Mental Health Manpower needs. The Commission is charged with presenting a report to the Governor by the end of June, 1965.

Parallel to this, but not a part of the Mental Health Planning Commission, is a second Commission appointed by Governor Breathitt, which is to plan for mental retardation facilities. The Commissioner of Mental Health is a member of both study Commissions and there are several physician-representatives on the Mental Retardation Planning Commission.

It is still too early to make any detailed report

of the Commission's findings since the studies are still under way. However, it appears to be the intent of the Commission to make an exhaustive study of the mental health needs in Kentucky to determine the gaps which exist in services now and to make recommendations on a long-range basis for a cooperative venture between Federal and State Governments and local communities. This seems to be developing in a parallel manner to the Hill-Burton Hospital Construction Program, which was instituted some years ago.

Frank M. Gaines, M.D.
KSMA Representative

Recommendations, Reference Committee No. 5

The long-range plans for the study of the Mental Health needs of our state is underway and the efforts of this representative are noted in this report.

It is recommended that these efforts be continued so as to make available all resources for Mental Health needs.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion seconded and carried.)

Resolution A

KMA Committee on Disaster Medical Care

WHEREAS, in the past few years, our national highway system has enjoyed a tremendous growth in interstate and other limited access highways, and

WHEREAS, this type of highway system will be even more elaborate in the years to come, and

WHEREAS, when sudden illness or injury occurs on these highways, which are no longer routed through our metropolitan areas, there is no easy method for knowing the location of hospitals for emergency treatment, and

WHEREAS, a minimum of time required in securing appropriate medical care and the use of emergency medical equipment such as would be found in a hospital can be life-saving, therefore be it

RESOLVED that the House of Delegates of the Kentucky State Medical Association go on record as requesting that necessary action be taken by the American Medical Association with the appropriate national agency or agencies in an attempt to secure the approval and placement of signs on our nation's major highways designating direction and distance to the nearest hospital, and further that an appropriate symbol be designed to show hospital location on maps, and further be it

RESOLVED that following its approval, this resolution be presented by the Kentucky Delegation to the next session of the House of Delegates of the American Medical Association.

Recommendations, Reference Committee No. 5

Although there are some aspects of this resolution that have not been spelled out as to detail, this reference committee recommends the adoption of this resolution because of agreement with its basic principles.

Mr. Speaker, I move the adoption and implementation of Resolution A. (The motion was seconded.)

During the discussion, Irving Kanner, M.D., Fayette County, made an amendment that Resolution A be accepted with the addition that the word "licensed" be placed before the word "hospital" in the resolved portion of the resolution. His amendment received a second. The vote on the amendment carried.

Resolution F

Campbell-Kenton County Medical Society

WHEREAS, the principle of free choice of physician and fee for service is the standard for medical practice in Kentucky, designed to preserve a doctor-patient relationship of the highest quality, and to make each physician fully responsible for his acts and,

WHEREAS, the medical profession has always cared for patients regardless of race, creed, or economic status, and shall continue to do so, and,

WHEREAS, a third party can do no more than to qualify a patient to receive funds for medical services rendered and,

WHEREAS, the physician alone is legally and morally responsible for the quality of medical service and,

WHEREAS, the medical profession pledges itself to the preservation of principles which have resulted in medical service of the highest quality, Therefore be it

RESOLVED, That the Kentucky Medical Association Board of Trustees evaluate any new plan to provide medical service by any public, private or governmental agency, at the request of any component Society of the Kentucky Medical Association.

This evaluation would determine whether the plan was consistent with the continual high standards of medical practice and in the best interest of the public. If not the Board of Trustees would inform the membership that participation be withheld.

We further recommend that a similar resolution be adopted on a national level by the American Medical Association, to be submitted by our American Medical Association delegates.

Recommendations, Reference Committee No. 5

This was reviewed in detail and the broad principle as outlined in this resolution was thought to be important enough for acceptance by this body of delegates.

Mr. Speaker, I move the adoption and implementation of Resolution F. (The motion was seconded and carried.)

Mr. Speaker, I move the adoption of Reference Committee No. 5 as a whole as modified. (The motion was seconded and carried.)

The Chairman of Reference Committee No. 5 wishes to thank all the committee members for their fine cooperation and assistance.

Reference Committee No. 5
David W. Kinnaird, M.D., Louisville, Chairman
Walter L. Boswell, M.D., Lexington
Carl J. Brueggemann, M.D., Covington
Owen Davis, M.D., Scottsville
Claude C. Waldrop, M.D., Williamstown

REFERENCE COMMITTEE NO. 6 †

N. L. Bosworth, M.D., Chairman
Reports on Constitution and Bylaws; Special Committees

† *See note (†) bottom of column one, page 962.*

Reference Committee No. 6 considered the following reports:

17. Report of the Advisory Committee to the Editor
18. Report of the Professional Relations Committee
19. Report of the Committee on Third Party Medicine
20. Report of the Constitution and Bylaws Committee
    Proposed Change in the Recommendation Offered in the Report of the Constitution and Bylaws Committee by the Delegates from Jefferson County Regarding Mandatory Orientation
14. Report of the Medical Discipline Committee Beginning on Page 3, Including its Nine Recommendations and the Proposed Bylaw Changes Beginning on Page 19
21. Report of the Interim Meeting Program Committee
22. Report of the Insurance Review Board
31. Report of the KSMA Representative on Kentucky Poison Control Program

Report of the Advisory Committee to the Editor

The Board of Trustees, at its first meeting following the last session of the House, directed that this Committee consult with the Editor in studying the cost of *Journal* production, and report to the Board specific recommendations for reducing *Journal* expenses.

The Advisory Committee reviewed the finances of the *Journal* in a daylong conference with the entire editorial staff. Detailed cost information had been prepared by the Managing Editor, and the entire group reviewed the cost and contents of the *Journal* in great detail. From these deliberations we were able to submit the following recommendations to the Board:

"A. That the *Journal* continue publication of the complete actions of the House of Delegates and the Constitution and Bylaws in each December issue. After weighing this material seriously, we feel that it should be available to every member of this Association.

"B. That the Scientific Section be reduced to nineteen pages, two of which will contain the Case Discussion.

"C. That the Maternal Mortality and Public Health pages appear in alternate issues.

"D. That the Insurance Page and the Blue Shield 'Question and Answer' page appear in alternate issues.

"E. That the Editorial, Special Article, and the Organization sections be carried as they have been, with Editorial vigilance in space conservation.

"F. That the Washington Page be omitted at editorial discretion.

"G. That the Book reviews be continued.

"We feel that Student KSMA subscriptions, already in effect at the rate of $4.00 for four years should be honored, but the offer should be discontinued. We advise that a package of *Journals* be available to interested students in each school through the Librarian. We suggest that the matter of student subscriptions is a part of the over-all problems of orienting students toward organized medicine, and that the Advisory Committees to the Medical Schools could advise the Editor on how the *Journal* could best help.

"County Society Reports could be an important help in drawing the members of the Association into a closer relationship. We request that the Trustees endeavor to stimulate reports to the *Journal* from their component societies."

These recommendations were adopted by the Board April 23rd and the Editor is implementing them.

The Sixtieth Anniversary Issue appeared in November, and was exceptionally well received. Doctor Eugene Conner, who served as Special Editor for that issue has received the thanks of this Committee, and of the Board of Trustees, for the excellent production. He is continuing to help as Book Review Editor.

The pattern of *Journal* income for the year indicates that the decline in revenue should soon be halted. Some improvement in revenue may be rather gradually anticipated, but the increase will be slow and probably not involve a recovery to the lush income previously enjoyed. The Managing Editor has been elected a Director of the State Medical Journal Advertising Bureau. As he is the only non-physician on the Board of this organization, we think this represents another recognition of the quality of the Kentucky Journal, and of his personal competence, as judged by his peers in this field.

Your Committee has again been impressed by the zeal and devotion of all members of the Editorial Staff. We have again found that the Kentucky Journal is outstanding among state journals. We feel that this is an indication that, to the Editorial Staff, the *Journal* is a labor of love, and not just another job.

ADVISORY COMMITTEE TO THE EDITOR
Blaine Lewis, Jr., M.D., Louisville
Andrew M. Moore, M.D., Lexington
Willett H. Rush, M.D., Frankfort
Orson P. Smith, M.D., Louisville
George F. Brockman, M.D., Greenville, Chairman

Recommendations of Reference Committee No. 6

This report was studied in detail and the committee made note of the recommendations that were made namely (a) that the Journal continue publication of the complete actions of the House of Delegates and the Constitution and Bylaws in each December issue, (b) that the scientific section be reduced to 19 pages, (c) that the Maternal Mortality and Public Health pages appear in alternate issues, (d) that the Insurance page and the Blue Shield "Question and Answer" page appear in alternate issues, (e) that the Editorial, Special Article, and the Organization sections be carried as they have been, (f) that the Washington page be omitted at editorial discretion and (g) that the Book Reviews be continued. It was felt by this committee that the student subscriptions already in effect for four years should be honored but the offer should be discontinued in the future.

That a request was made that the trustees endeavor to stimulate reports to the Journal by component societies.

It is encouraging to note that the income from the Journal for the year indicates that the decline in revenue should soon be halted. This report was approved by the Board of Trustees on August 6, 1964.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Professional Relations Committee

No issues were referred to this committee and no meetings were held.

PROFESSIONAL RELATIONS COMMITTEE
E. B. Mersch, M.D., Covington, Chairman
Irvin Abell, Jr., M.D., Louisville
David M. Cox, M.D., Louisville
Robert W. Robertson, M.D., Paducah
G. L. Simpson, M.D., Greenville

Recommendations, Reference Committee No. 6

It was noted that no issues were referred to this committee and no meetings were held. Board action: Approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Committee on Third Party Medicine

To our knowledge, providers of Third Party Medicine have not been a major problem since the last session of the House of Delegates. For this reason, our Third Party Committee did not have a meeting.

The UMWA hospitals, which formerly created many of our problems, have new ownership, and the hospital chain is now known as Appalachian Regional Hospital, Incorporated. Our KSMA Hospital Committee and Executive Committee of the Board of Trustees have been meeting with the ARHI representatives since most of the hospital matters pertain to these two committees.

Although our Third Party Committee has been inactive during the past year, it is recommended that

this Committee be continued and stand ready for any Third Party problem which may arise.

COMMITTEE ON THIRD PARTY MEDICINE
Ballard W. Cassady, M.D., Pikeville
Walter L. Boswell, M.D., Lexington
Robert Jasper, M.D., Somerset
Robert E. Norsworthy, M.D., Hartford
John S. Harter, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 6

This reference committee noted that there had been no major problems since the last session of the House of Delegates and no meetings were held. Board action: Approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Constitution and Bylaws Committee

Your committee held one meeting on the 10th of June to continue its study of the Constitution and Bylaws and to implement the matters referred to it by the Board of Trustees.

Clarification of Membership

The committee gave lengthy consideration to how the Bylaws might be written to avoid apparent misunderstandings relative to the relationship of membership in the state association and the county society. The first sentence of Chapter I, Section 1 covering this matter reads as follows:

"A member of this Association must also be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership."

In order to fully delineate this matter, the committee proposes the following amendment to the first sentence, which would read as follows:

Membership in this association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership.

(The italic type indicates the proposed rewording of the sentence).

Recommendations, Reference Committee No. 6

This report was carefully reviewed and the first recommended change was that of membership contained in the first sentence of Chapter 1, Section 1 of the Bylaws. As the Bylaws now read:

"A member of this Association must also be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership."

Recommended change is as follows:

MEMBERSHIP IN THIS ASSOCIATION SHALL BE COTERMINOUS WITH MEMBERSHIP IN A COMPONENT COUNTY SOCIETY. NO PHYSICIAN SHALL BE ELIGIBLE FOR MEMBERSHIP IN THIS ASSOCIATION UNLESS HE IS A MEMBER, IN GOOD STANDING OF A COMPONENT SOCIETY, NOR MAY HE MAINTAIN MEMBERSHIP IN A COMPONENT COUNTY SOCIETY UNLESS HE IS A MEMBER, IN GOOD STANDING OF THIS ASSOCIATION. WHEN A PHYSICIAN WHO MEETS THE QUALIFICATIONS HEREINAFTER SET FORTH, IS CERTIFIED TO THE SECRETARY AS A MEMBER IN GOOD STANDING OF A COMPONENT SOCIETY, PROPERLY CLASSIFIED AS TO TYPE OF MEMBERSHIP, and when the dues pertaining to his membership classif-, etc. . . .

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion was seconded and carried.)

Report of the Constitution and Bylaws Committee (Continued)

Professional Relations Committee

Due to the changes in grievance procedures approved by the 1963 House of Delegates, the committee felt that the Professional Relations Committee no longer served a purpose. However, until final recommendations for Bylaws change were received from the Committee on Medical Discipline, it was decided that no change in the Professional Relations Committee would be recommended at this time.

Recommendations, Reference Committee No. 6

No change in the Professional Relations Committee was recommended.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Constitution and Bylaws Committee (Continued)

Mandatory Orientation

Following a lengthy period of study by the Council on Communications and Public Service, the 1963 session of the House accepted the Council's recommendation that the Association proceed with a mandatory orientation program for all new members. In accordance with a special study by a sub-committee of the Council on Communications and the Council itself, the Bylaws Committee recommends that the following new section implementing the 1963 action of the House of Delegates on mandatory orientation be added to the Bylaws and be known as Section 5 of Chapter 1.

5. Every active member shall occupy a provisional status for two pears immediately following his admission to membership in the Association, during which period he must successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within the two-year period shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component county society.

Amendment of Mandatory Orientation Proposal Submitted by the Delegates from Jefferson County Medical Society

The Delegates from the Jefferson County Medical Society agree in principle with the recommendation of the Council on Communication concerning a new member orientation program. We wish to point out that this Society has an orientation program for new members which not only explains the purpose and operation of the County Society but also covers important and necessary points concerning the Kentucky State Medical Association. We feel that for new members of this County Society to attend a mandatory orientation program of the State Association would be a duplication of effort and unnecessary inconvenience to the new physician.

This Society Delegation is in sympathy with the intent and purpose of this recommendation and agrees with the new Bylaw section as printed in report Number 20, Page 2, however desires to amend this new section in order that a State Association Trustee might attend and participate in the Jefferson County Society program thus fulfilling the orientation needs for all new members in our society.

We therefore offer an amendment to the new section of the Bylaws which is to be known as Section 5 of Chapter 1. Section 5 would then read as follows (our amendment shown by italics):

5. Every active member shall occupy a provisional status for two years immediately following his admission to membership in the Association, during which period he must successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees, *or an approved orientation course of a component County Society, supervised by and under direction of Board of Trustees.* The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within the two-year period shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component county society.

Recommendations, Reference Committee No. 6

Mandatory Orientation. The committee again studied this in detail and felt that the proposed change recommended in the report of the Constitution and Bylaws Committee should remain as recommended namely:

(Chapter I, Section 5)

EVERY ACTIVE MEMBER SHALL OCCUPY A PROVISIONAL STATUS FOR TWO YEARS IMMEDIATELY FOLLOWING HIS ADMISSION TO MEMBERSHIP IN THE ASSOCIATION, DURING WHICH PERIOD HE MUST SUCCESSFULLY COMPLETE AN ORIENTATION COURSE TO BE PRESENTED AT STATED INTERVALS BY THE BOARD OF TRUSTEES OR ONE OF ITS COMMITTEES. THE FORM AND CONTENT OF THIS COURSE SHALL BE PRESCRIBED BY THE BOARD AND UNLESS EXCUSED BY THE BOARD FOR GOOD CAUSE SHOWN, FAILURE TO ATTEND AND SUCCESSFULLY COMPLETE THE COURSE WITHIN THE TWO-YEAR PERIOD SHALL AUTOMATICALLY REVOKE THE DELINQUENT'S MEMBERSHIP AND TERMINATE ALL OF HIS RIGHTS AND PRIVILEGES AS A MEMBER, AND HE SHALL THEREAFTER, FOR A PERIOD OF ONE YEAR, BE INELIGIBLE FOR MEMBERSHIP IN ANY COMPONENT COUNTY SOCIETY.

The proposed change in the recommendation offered in the report of the Constitution and Bylaws Committee by the Delegates from Jefferson County Regarding Mandatory Orientation was as follows:

5. EVERY ACTIVE MEMBER SHALL OCCUPY A PROVISIONAL STATUS FOR TWO YEARS IMMEDIATELY FOLLOWING HIS ADMISSION TO MEMBERSHIP IN THE ASSOCIATION, DURING WHICH PERIOD HE MUST SUCCESSFULLY COMPLETE AN ORIENTATION COURSE TO BE PRESENTED AT STATED INTERVALS BY THE BOARD OF TRUSTEES OR ONE OF ITS COMMITTEES, *OR AN APPROVED ORIENTATION COURSE OF A COMPONENT COUNTY SOCIETY.** THE FORM AND CONTENT OF THIS COURSE SHALL BE PRESCRIBED, ETC. . . .

After considerable deliberation, it was felt by this committee that this proposal would weaken the objectives of such a course and in addition would duplicate efforts.

Mr. Speaker, I move the adoption and implementation of this section of the report as originally written. (Motion was seconded and carried.)

**Note: James M. Riley, M.D., Jefferson County, pointed out that the amendment from Jefferson County on mandatory orientation should read . . . "or an approved orientation course of a component county society supervised by and under direction of Board of Trustees."*

Report of the Constitution and Bylaws Committee (Continued)

Number of People to Serve on the Council

Chapter VII, Section 1 provides that no less than five and no more than seven members may serve at any one time on one of the Councils of KSMA. The 1963 meeting of the House of Delegates accepted a recommendation from the Council on Medical Education and Hospitals that both deans be added to the Council, which would bring the total membership to eight.

This was also discussed at length by the Bylaws Committee, which recommends that the number of people to serve on a Council remain at the present Bylaw limit and that one of the chairmen of the committees under the Council also serve as chairman of the Council.

Recommendations, Reference Committee No. 6

Number of People to Serve on any of the Six KSMA Councils. Recommendation the same.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Constitution and Bylaws Committee (Continued)

Procedure for Reporting House of Delegates Digest in Journal of KSMA

The Bylaws Committee gave consideration to present procedures for reporting the actions of a committee through the Council, the Board of Trustees, and the House of Delegates in an effort to simplify the procedure. The following recommendation does not involve a Bylaw change but is a recommendation to the Board of Trustees. In reporting the actions of the 1964 House of Delegates in The Journal on the work of the various councils and standing committees, it is recommended that if no dissenting action to the committee's recommendations is made either by the Council under which the committee serves or the KSMA Board of Trustees, that only the reference committee action on the report be printed in The Journal. Appropriate note would be made of this new procedure at the beginning of the report.

The purpose of this recommendation is to shorten the report and make it easier to understand.

Recommendations, Reference Committee No. 6

Procedures for Reporting the House of Delegates

Digest in the Journal of KSMA. There is no Bylaw change involved in this recommendation and it is merely a recommendation to the Board of Trustees to the effect that in reporting the actions of the 1964 House of Delegates in the Journal on work of the various councils and standing committees, it is recommended that if no dissenting action to the committee's recommendations is made either by the council under which the committee serves or the KSMA Board of Trustees, that only the reference committee action on the report be printed in the Journal.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Constitution and Bylaws Committee
(Continued)

Change in Constitution

The 1963 House of Delegates adopted the following recommendation made by the Committee to Study the Constitution and Bylaws "that in order to avoid confusion by lay people in thinking this is a part of state government the name of Kentucky State Medical Association be shortened to that of Kentucky Medical Association".

Article XII of the Constitution says that it may be amended provided the following conditions are met: 1. That the recommendation lay over for a period of a year; 2. That each county society be given official notice of the proposed change at least two months in advance. Both of these provisions have been met.

Your Bylaws Committee now recommends that the name of the Association be changed from the Kentucky State Medical Association to the Kentucky Medical Association. The Constitution provides that it takes a two-thirds vote of the delegates registered at the session to change the Constitution.

Your committee also recommends that it be given permission to delete the word "state" wherever it appears in the title of our association in the Bylaws.

Recommendations, Reference Committee No. 6

Change in Constitution. The committee was in whole-hearted support of the change of the name of the Kentucky State Medical Association to the Kentucky Medical Association. The requirements for this Constitutional change have been met.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Constitution and Bylaws Committee
(Continued)

Status of KSMA Woman's Auxiliary

It was explained to the committee that all official KSMA records up to January of 1937 were destroyed in the flood. At that time the association's offices were located in the basement of the State Department of Health Building at Sixth and Main.

The General Counsel stated that he was unable to find any record of the Woman's Auxiliary being an official adjunct of KSMA and he felt that there should be some official action indicating that the Auxiliary was an official adjunct of the organization. All members of the committee were convinced that at some time prior to 1937 appropriate action in this connection had been taken by the Association despite the fact there was no record of it.

While the committee does not recommend an amendment to the Bylaws in this connection, it would recommend that the following resolution adopted by the KSMA Board of Trustees, be approved by the House of Delegates as the Association's policy in this matter:

WHEREAS, the Woman's Auxiliary to KSMA has for many years preformed numerous useful and constructive services to organized medicine in this state, and

WHEREAS, there appears to be nothing on record which acknowledges the Auxiliary's status with respect to the Association, and

WHEREAS, the Board of Trustees deems it desirable that its long-established recognition be reaffirmed of record,

NOW THEREFORE BE IT RESOLVED that the Board of Trustees, on behalf of the Association, extend recognition to the "Woman's Auxiliary to the Kentucky State Medical Association" as an organization of wives, daughters and widows of members of this Association affiliated with but not a part of said association, so long as said Auxiliary's aims and purposes remain consistent with and complementary to those of the Association, with the request that it furnish the Association a copy of its charter and bylaws and all amendments, and report its activities at least annually to the Board.

COMMITTEE TO STUDY THE CONSTITUTION AND BYLAWS
James S. Baughman, III, M.D., Harrodsburg
Bruce Hamilton, M.D., Shepherdsville
Douglas H. Jenkins, M.D., Richmond
James G. Sills, M.D., Hardinsburg
E. C. Strode, M.D., Lexington
Robert S. Dyer, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 6

Status of the Woman's Auxiliary. The committee whole-heartedly endorsed the recommendation of this committee to officially recognize the KSMA Woman's Auxiliary. Board action: Approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of the Medical Discipline Committee of the Council on Medical Services

Medical Discipline Committee, Robert E. Pennington, M.D., London, Chairman

The Medical Discipline Committee met on Wednesday, May 27. Prior to making its recommendations, the committee felt that the following background information would be helpful.

In 1961 Laurel County Medical Society introduced a resolution asking the House of Delegates to instruct its president to cause a bill to be drafted for the legislature to enact a law creating a judicial body within the medical profession of Kentucky. The committee would be given the power to subpoena, hear testimony, judge inept medical practices, as well as unethical conduct, and be able to enforce disciplinary action such as fines, suspensions, or revocations of licenses. The resolution further asked that doctors who served on the committee possess immunity under the law from civil action.

The idea for this resolution came as a result of several states, particularly Washington, passing such laws giving physicians power to discipline the members of their profession. We later found the State Board of Health has authority to do everything called for in the resolution with the exception of some things concerning medical ethics.

It is a recognized fact that most county societies have memberships too few in number to have effective judicial committees. Because of this, the KSMA Board of Trustees created fifteen trustee district grievance committees, each composed of three trustees. At the time these committees were initiated, it was felt that each could render decisions on its own; however, the plaintiff could take his appeal to the Board of Trustees. Some of the grievance committees did not desire to render the final decisions and asked that the Trustees make these decisions. There were no guidelines for uniformity among the different committees.

Mr. Davis said he recommended that the rules be changed and the grievance committee only make recommendations to the Board of Trustees. He said this would take a little longer to get a final decision,

but the doctor involved would know that an even hand was applying discipline. So, having solved one problem, we created another because the Board of Trustees had too much to do already. The problem now is how to maintain a workable and aggressive disciplinary system without overburdening the Board and still assuring a doctor who is in trouble that a standard of discipline would apply to him the same as to a doctor in another area.

This committee is one of many under the Council on Medical Services. Some time ago the Council outlined the proposed duties of this committee and, with one change by the Board of Trustees at its meeting on April 22, the duties are as follows:

> This committee shall have the responsibility of investigating, with the assistance of the Association's legal counsel when necessary, the adequacy of disciplinary rules, laws, and procedures as applied to medical practice, licensure, and medical society membership, and the degree to which efficient discipline is maintained among medical practitioners as may be referred to it by proper agencies of the Association, and make recommendations to the Board of Trustees.

Bylaws of judicial committees were obtained from California and New York Medical Associations and each member of the committee was given a copy. Mr. Davis said evidently the AMA thought the Texas Medical Association had good bylaws for a judicial council because they were on the program during a recent AMA meeting dealing with this subject. Doctor Pennington asked that Headquarters Office photocopy the Texas bylaws on discipline and mail same to each member on the committee. Doctor Pennington then commented on the structure and procedures of operation of the judicial councils in the states mentioned above.

Mr. Davis had a copy of "Conclusions and Recommendations in the Report of the Medical Discipline Committee to the Board of Trustees, American Medical Association, June, 1961." From this he read portions which would be helpful to any state in the way of guidelines for forming a judicial council.

After considering all of the foregoing, this committee makes the following recommendations:

1. That all KSMA committees dealing with disciplinary problems, with the exception of the district grievance and insurance review committees, be abolished.

2. That all disciplinary powers and functions of the Board of Trustees be transferred to a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates, upon nomination of the Board of Trustees, for terms of four years. Additional Nomination from the floor should be permitted. One member of the Judicial Council should be nominated from each of the eastern, western, and central districts, and one member at large. Terms of the initial nominees should be staggered so that one man is elected each year, and no member should serve more than two full terms. Vacancies should be filled by the Board. A majority of the members should constitute a quorum.

3. That nominees for election to the Judicial Council have at least one of the following four qualifications: (a) Served five years in House of Delegates; (b) Served one term as an officer, trustee, or delegate to the AMA.

4. That present disciplinary appellate procedures remain the same, with the exception that appeals be taken to the Judicial Council instead of the Board of Trustees, the decision of the Judicial Council being final except for any appeal to the Judicial Council of the AMA.

5. That the Judicial Council be placed administratively on the same level as other councils and report to the House of Delegates via the Board of Trustees.

6. That the Judicial Council be given authority to initiate disciplinary proceedings against any member, and to intervene in and supersede county or district disciplinary proceedings whenever, in the opinion of the council, a disciplinary matter is not being handled in an expeditious manner.

7. That if the Judicial Council should find that a member's license should be revoked, it reports this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

8. That the larger county societies be encouraged to form grievance committees and advised that the district grievance committees should be utilized only when the manner cannot be handled at the county level.

9. That the Insurance Review Committee be instructed to refer all matters coming to its attention which appear to merit disciplinary action, to the Judicial Council for appropriate action which may include referral to the county or district grievance committee.

It was also taken by common consent that the Council on Medical Services recommend that the proposed Bylaws changes outlined below be voted upon at this 1964 Annual Meeting in order that the report of the Medical Discipline Committee can be implemented during the 1964-1965 Associational year.

PROPOSED AMENDMENTS TO KSMA BYLAWS

1. Chapter VI, Section 4: Strike this section in its entirety and re-number succeeding sections.

2. Chapter VII, Section 1: Strike subsection (c) and re-letter succeeding subsections.

3. Chapter VII, Section 9: Strike this section in its entirety and re-number succeeding sections.

4. Create a new Chapter VII (by re-numbering present Chapter VII and succeeding chapters) as follows:

CHAPTER VII. DISCIPLINE—THE JUDICIAL COUNCIL

"Section 1. There is hereby created a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively, so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

"To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

"It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary, shall serve more than two consecutive terms.

"Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offend-

ing member's license to practice medicine should be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

"It may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings whenever in its sole judgment and opinion, a disciplnary matter is not being handled in an expeditious manner, and may render a decision therein. In all such cases of initiation, intervention, or supersession, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

"Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In the case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

"Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

"Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final.

"Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

"Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

"Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation, the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable the Judicial Council to form its own conclusions.

"If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall each be entitled to the counsel of any physician of his choice, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

"When all of the testimony has been heard and all evidence received, the committee shall make written findings and recommendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

"Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies."

5. Chapter XI (new XII), Section 7: Strike parenthetical sentence at end.

6. Chapter XI (new XII), Section 6: Amend proviso to read: "Provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees, be eligible for membership in any component society."

7. Chapter XI (new XII), Section 10: Substitute "Judicial Council" for "Board of Trustees" in paragraphs 3 and 4, leaving paragraph 5 as is.

Recommendations, Reference Committee No. 6

This committee heard arguments both pro and con on paragraph two, page 21, Report No. 14, which states:

> "It may *initiate* disciplinary proceeding against any member, and may *intervene* in or *supersede* county, individual trustee, or district disciplinary proceedings whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all such cases of initiation, intervention, or supersession, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council."

After due consideration, the committee proposes the following substitution in paragraph 2, page 21, Report No. 14.

> AT THE REQUEST OF ANY MEMBER OR AGGRIEVED INDIVIDUAL INVOLVED, THE JUDICIAL COUNCIL may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings whenever in its sole judgment and opinion, . . .

This committee based its conclusion not on personalities involved but on principles involved.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion was seconded and carried.)

Section 9, page 23, Report No. 14 reads:

> "Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committe has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies."

This committee would recommend the addition to Section 9 as follows:

> . . . "directing the attention of the Judicial Council to those portions of the transcript upon which he relies, 'PROVIDED, HOWEVER, THAT THE JUDICIAL COUNCIL MAY EXTEND THE TIME IN WHICH THE TRANSCRIPT MUST

BE FILED, UPON REQUEST MADE WITHIN THE INITIAL THIRTY-DAY PERIOD.'"

The thinking behind this was that in many instances where the transcript involved quite a tremendous amount of material, that it would take longer than thirty days for this transcript to be prepared.

Mr. Speaker, I move the adoption and implementation of this section of the report. (Motion seconded; carried.)

Report of the Interim Meeting Program Committee

Your committee met late in the fall of 1963 to plan the 1964 meeting which was held at Jenny Wiley State Park, April 23. (The Committee also met at the Park.)

The program was carefully planned and a vigorous promotion was scheduled. Plans for housing the overnight guests were made and duties were delineated and assigned.

As a result of all of these efforts, a new high in registration for the meeting of 215 was reached. The speakers at the Conference were outstanding.

Your committee would like to thank all who worked so hard to make this meeting enjoy this unusual success.

Interim Meeting Committee
James D. Adams, M.D., Prestonsburg
William Hambley, M.D., Pikeville
Douglas E. Scott, M.D., Lexington
George P. Archer, M.D., Prestonsburg, Chairman

Recommendations, Reference Committee No. 6

This report deals with the Interim Meeting held at Jenny Wiley State Park and congratulates the committee responsible for this meeting. Board action: approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of the Insurance Review Board

The Kentucky State Medical Association Insurance Review Board came into being in August, 1963. A Canvass by mail revealed the members were of the opinion we need meet only when the matter under consideration required discussion in detail. Accordingly, the Board has held one meeting. We have considered a total of three complaints submitted to us.

Each member of the Board has been asked to submit criticisms and suggestions concerning the form and function of this Board. These will be attached, if any.

Insurance Review Board
Bernard J. Baute, M.D., Lebanon
Harvey Chenault, M.D., Lexington
John Dickinson, M.D., Glasgow
Albert S. Irving, M.D., Louisville
Paul H. Klingenberg, M.D., Covington
Alfred O. Miller, M.D., Louisville
Jack L. Chumley, M.D., Louisville, Chancellor

Recommendations, Reference Committee No. 6

One meeting was held. Board action: approved.

Mr. Speaker, I move the adoption of this section of the report. (Motion was seconded and carried.)

Report of KSMA Representative on Kentucky Poison Control Program

While the Kentucky Poison Control Council has been reasonably active during the past year, there have been no dramatic developments and all business has been of a routine matter. We have enjoyed our association on this Council.

Arnold C. Williams, M.D.
KSMA Representative

Recommendations, Reference Committee No. 6

There have been no new developments brought out to this committee.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

As chairman, I would like to express appreciation to the members of this committee for their diligent, dedicated work on this committee.

Mr. Speaker, I move the adoption and implementation of this report as amended. (The motion was seconded and carried.)

Reference Committee No. 6
N. L. Bosworth, M.D., Lexington, Chairman
J. S. Baughman, M.D., Harrodsburg
J. C. Cantrill, M.D., Georgetown
Ralph D. Lynn, M.D., Elkton
Henry Post, M.D., Louisville

REFERENCE COMMITTEE NO. 7 †

L. F. Beasley, M.D., Chairman
Miscellaneous Reports

† *See note (†) bottom of column one, page 962.*

The reports this reference committee considered are as follows:

25. Report of the McDowell Home Committee
26. Memorials Commission
28. KSMA Representative to Conference of Presidents and Other Officers of State Medical Association
29. KSMA Representative, University of Kentucky Chapter Student AMA
30. KSMA Representative, University of Louisville Chapter, Student AMA
33. Representative, Advisory Committee on Maternal and Child Health, State Department of Health

Reference Committee No. 7 has studied reports Nos. 25, 26, 28 (less paragraph 3 on page 4 and the accompanying financial report), 29, 30 and 33.

Report of the McDowell Home Committee

Your Committee views with pride the restoration of the Ephraim McDowell Home and the re-assembling of those professional and personal possessions of one of the outstanding figures of all time in medicine. Your Committee is proud to follow in the footsteps of the three recent Committees with their distinguished Chairmen, Irvin Abell, Sr., M.D., Charles A. Vance, M.D., and Francis M. Massie, M.D. Over the years numerous other distinguished members of our Association have added greatly to the fruition of the restoration in its present state. These included Samuel Gross, M.D., John D. Jackson, M.D., August Schachner, M.D., J. N. McCormack, M.D., C. C. Howard, M.D., A. T. McCormack, M.D., and many others.

This Committee has had two formal meetings this year and plans a third for early September. The first meeting took place at the Hunt-Morgan House in Lexington, Kentucky on January 18, 1964. The prime purpose was to receive the discovery by Doctor Massie of the McDowell Library, and the second to receive a valuable antique gift by Charles Pfizer Company. To this luncheon meeting were invited Charles N. Tarkington, M.D., a descendant of Doctor McDowell, Dr. Thomas O. Clark, Professor of History, University of Kentucky, Dr. Lawrence Thompson, Librarian of the University of Kentucky, Miss Roeson Henry, Librarian of Transylvania College, Dr.

Omer Hamlin, Jr., Librarian at the University of Kentucky, Mr. Winston Coleman, local historian, George Doyle, M.D., collector of rare books, Mrs. Hill Shine of the Rare Book Room of the University of Kentucky, Mr. Thomas Underwood of the Barkley Room of the University of Kentucky, and members of the press.

Doctor Massie had obtained from Otto Brantigan, M.D., of Baltimore, who in turn had received from the Reverend Michael Barton of Accomac, Virginia, books which composed the library of Ephraim McDowell, M.D. The Reverend Barton had received the books from a granddaughter of Doctor McDowell. She was the daughter of Alexander, and had a sister, Lucy Meader, who was living at the Alms Hotel, Cincinnati around 1940. The library included 26 printed medical books of the late 18th century and one hand-written volume, "A Medical Commonplace Book." The latter may have represented a notebook kept by Doctor McDowell. These books now repose in the Rare Book Room of the Library of Transylvania College. Richard H. Segnitz, M.D., of this Committee, Dr. Norman H. Franke, of the College of Pharmacy of the University of Kentucky, and the local librarians are studying these books for their historical significance.

A second part of that Committee Meeting included the presentation by Walter Bett, M.D., Editor of Spectrum, Charles Pfizer Company, of a rare pill tile, pill cutting machine and pill rounder, to the Kentucky State Medical Association. The Wedgewood tile is one of two of the type known to be existing today. This rare and valuable gift has been added to the unusual display in the Apothecary Shop of the McDowell Home.

A business meeting of the Committee followed these presentations.

A second Committee Meeting was held in the McDowell Home, April 19, 1964, when the house was carefully examined by the members and a long discussion followed.

The expenses of maintaining the McDowell Home approximate $6,000 per year, and it is anticipated these will increase as the restoration becomes older and more maintenance is required. $3,000 is appropriated from the State Medical Association, $1,000 is from the Kentucky Surgical Association, $1,000 from admissions, and the remainder is irregularly contributed by other medical organizations; the latter has been particularly irregular.

In the Spring of 1964 it was necessary to replace deteriorated weather boarding on the south side of the house, some of the brick work, and replace some rotton flooring on the rear porch. This cost just over $1,500 which caused an immediate deficit for a few months. This is the largest repair bill in the last few years, but we must realize that further major repairs may be necessary in the near future. A budget must anticipate this situation.

A Sub-Committee on Finance, consisting of David Kinnaird, M.D., Rankin C. Blount, M.D., and George W. Sweeney, M.D., will submit a budget to the Home Committee for supplies, repairs, painting (needed in the immediate future), personnel, insurance, publicity, telephone, gas and electricity, miscellaneous services, payroll and sales taxes. Finances must be budgeted for probably major repairs at least every three years. It is desirable to obtain funds for a fireproof room and safe for the protection and preservation of some of the most valuable objects, including personal letters of McDowell, his library and even the original oil painting by Davenport, lent to the State Department of Health in Frankfort. Funds for other improvements, enumerated below, may be sought.

A Historical Sub-Committee composed of Doctor Segnitz, Dean Earle P. Sloane of the College of Pharmacy of the University of Kentucky, and Mr. Sterling Coke, are investigating the historical significance of the recently discovered library, are obtaining information on reproduction of the original letters which are fading rapidly, are summarizing information on all authentic McDowell personal properties and letters, and will collect the truly historical information on Cambus Kenneth and its remaining original McDowell buildings.

It is anticipated that a Planning Sub-Committee will offer definitive suggestions in regard to a small kitchenette for use by various committees of the Medical Association and other organizations, for improved powder room facilities, for fireproofing the office or the rear room of the Apothecary Shop, or possibly the construction of a small, fireproof museum room on the rear of the property for the protection of valuable items.

An encouraging new development is the recent action of the Danville and Boyle County Historical Society. On June 14, 1964, the Historical Society endorsed a proposal to establish a memorial in Danville to the first Governor in Kentucky, Isaac Shelby. Resolutions were adopted and forwarded to the Commissioner of State Parks and the Governor, asking that the State give consideration to the enlargement of Constitution Square in Danville, and the erection of a Shelby Memorial in the ground now occupied by commercial buildings between Constitution Square and the McDowell Home.

It was noted that Doctor McDowell's wife was Sarah Shelby, the daughter of Isaac Shelby. This was presented to the Commissioner of State Parks, Robert D. Bell, June 16, 1964. This entire activity was stimulated by Doctor Massie. It is felt that the physicians should remain in the background and aid the historical societies in pressing this project which will be of immense value to the protection of the McDowell Home and add to its increasing attractiveness to tourists to learn of this medical heritage of Kentucky.

It is a matter of pride that the Association should continue to maintain this National and World Shrine in a proper manner. The financial contribution of the Kentucky State Medical Association is obviously necessary, and it is logical to increase this contribution from $3,000 to $4,000 per annum.

Attached is the financial report as prepared by the financial office of the Kentucky State Medical Association.

THE MCDOWELL HOME COMMITTEE
Robert Bateman, M.D.
Rankin C. Blount, M.D.
Mr. Sterling Coke
Mr. George Grider
E. M. Howard, M.D.
David Kinnaird, M.D.
Dean Earl P. Sloane
Richard H. Segnitz, M.D.
George W. Sweeney, M.D.
Laman A. Gray, M.D., Chairman

Recommendations, Reference Committee No. 7

Reference Committee No. 7, has studied the report of the McDowell Home Committee and we recognize and appreciate the work that has been done by the Committee. We also recognize the significance of the McDowell Home and Apothecary from the standpoint of the history of medicine in Kentucky and the world. We also note the recommendations of the Committee and note the deficit involved. In reference to the request for funds, this portion of the report was referred to Committee No. 1.

Mr. Speaker, I move the adoption of this section of the report. (The motion was seconded and carried.)

Report of the Memorials Commission

Your commission held its meeting on March 18 at the KSMA Headquarters Office.

Plans were made for the development of a limited

museum, using only the most carefully selected of appropriate items.

One of the functions of the Commission is to provide the financing of the furnishings of the Board Room of the Headquarters Office. It is pleased to report that already twenty-three of the chairs at $75 a chair have been assigned. The contributor's name, on a small, uniform plaque, will be placed on the back of each chair.

The Commission has contacted the past presidents and some of the families of the late past presidents and offered them an opportunity to contribute $100 each to the President's Office-Museum. Already, $1,000 has been collected. These funds are being held in a separate account for use in furnishing the museum.

Your chairman would like to express his appreciation to the members of the Commission for their interest and assistance.

MEMORIALS COMMISSION
G. Y. Graves, M.D., Bowling Green
Francis Massie, M.D., Lexington
Carlisle Morse, M.D., Louisville
Wyatt Norvell, M.D., New Castle
J. Duffy Hancock, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 7

Reference Committee No. 7 has noted the efforts and success of the Memorials Commission and feels that they should be commended for their efforts.

Mr. Speaker. I move the adoption of this section of the report. (The motion was seconded and it carried.)

Report of KSMA Representative to Conference of Presidents and Other Officers of State Medical Associations

A large attendance was on hand when the Twentieth Annual Meeting of the Conference was called to order by President J. Lafe Ludwig in the Gold Room of the Fairmont Hotel in San Francisco. Doctor Ludwig introduced the president-elect, Raymond McKeown, M.D., who gave a stimulating talk on "Strength in Unity."

Very fine presentations were made by two California candidates for the United States Congress.

Mr. Allan B. Kline, past president of the American Farm Bureau, made an excellent speech on "What Price Freedom," and "Prerequisites for Political Health" was the title of a presentation by the former dean of Law School at Notre Dame University, Clarence E. Manion, J.D. These presentations were well received and were regarded as highly profitable.

George P. Archer, M.D., President
Kentucky State Medical Association

Recommendations, Reference Committee No. 7

Reference Commottee No. 7 recommends that the House of Delegates express its appreciation to our President for attending this meeting.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of KSMA Representative, University of Kentucky Chapter, Student AMA

Our local SAMA organization is beginning to shape up with the first four years having been an ordeal. I had several prolonged telephone conversations with some of the more ardent members and thereafter attended the final meeting of the year, at which time election of officers and a platform of activities was drawn up. The concluding session of the year was an all Medical School dance which was a resounding success.

It is believed that the chapter now anticipates serving as both an off-spring of the AMA, tending to both academic and social needs of the Medical School as a whole. I think they now understand that in the absence of fraternities and sororities—other student government bodies—that their role is a multilateral one.

I also think that the liaison between men such as myself and the other members of the Fayette County Medical Society has been improved and this will be enlarged upon.

Richard H. Segnitz, M.D., KSMA
Representative to U of K Chapter

Recommendations, Reference Committee No. 7

Our committee recognizes the importance of maintaining personal contacts and establishing liaison between practicing physicians and future doctors of our state, and feels that this relationship will be valuable to all concerned. Our representative to the University of Kentucky Chapter is to be commended for his efforts.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of KSMA Representative, University of Louisville Chapter, Student AMA

The past year has been one of continuing activity for the chapter at this school. They have been quite active and have attended local, regional, and the national SAMA meeting in Chicago in May of 1964.

The students hold monthly meetings during the school year and have worked in close cooperation with Dean Donn Smith in his first year of proprietorship at the school. The general rapport amongst the student body and amongst the profession can be attributed to the active efforts of the boys in the SAMA chapter and again one cannot fail to be impressed by the interest and enthusiasm that these boys have towards the problems of the private practice of medicine and to their efforts to try to help us. This was again exemplified by the strong stands that they took at the national SAMA meeting, at which time, they again voted against King-Anderson type legislation and again they were vigorous in their support of only bricks and mortars federal aid. Our boys have a record through the years of being in complete agreement with the AMA's House of Delegates in all of these matters and again they were most instrumental in committee meetings in supporting these just causes.

It was again a pleasure to have the opportunity and privilege of seeing the younger generations of medicine continuing to step into the arena and contribute their part.

Hoyt D. Gardner, M.D., KSMA
Representative to U of L Chapter

Recommendations, Reference Committee No. 7

Again our committee recognizes with approval the efforts of the representative of our association to further the orientation of future doctors to our philosophy and problems, and recommends that he be commended on the success of his efforts.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Report of KSMA Representative, Advisory Committee on Maternal and Child Health

State Department of Health

The fifth and sixth meetings of the Maternal and Child Health Advisory Committee were held in Louisville and at Kentucky Dam Village. Your KSMA representative was unable to attend but has reviewed the minutes of each meeting very carefully.

Attendance was good at both meetings. A repre-

sentative group of practicing physicians from all sections of the state attended. Holding the committee meetings in different sections of the state seemed to improve attendance. It was agreeded to continue this practice.

At the first meeting in Louisville in January, discussion was given to the continued need for premature and Rh treatment centers in outlying areas. However, due to lack of funds, no progress has been made in this direction. Hospitals in the areas involved are able to take care of the prematures and Rh problems arising in their own hospital but do not have the facilities needed to accept babies born outside the hospital. The University of Kentucky does have a premature nursery with ten beds available which can be used for babies from outside the hospital. This nursery is financed, in part, by the Maternal and Child Health funds. The University of Louisville with the acquisition of additional staff in July may consider establishing such a center also.

Doctor Fraser reported on the plans for Western Pediatric Clinics similar to the Eastern Pediatric Clinics which have been in progress for two years under the direction of the University of Kentucky Center. At present, the Bowling Green clinic is manned by the donated services of Pediatricians in the area. These clinics are confined to indigent patients and the determination of indigency is made locally. Funds are still lacking for hospitalization, laboratory diagnostic work, and for transportation of these indigent patients to Louisville or Lexington as the case may be.

The meeting was closed with a suggestion that the Committee undertake some type of survey to determine the number and types of defective and crippling diseases existing among the children in Kentucky. This will be explored further.

At the sixth meeting at Kentucky Dam Village in April, discussion centered around the need for more Pediatric Clinics in Western Kentucky. A representative group of physicians from throughout Western Kentucky were present. One practicing Pediatrician stated that we could improve on pediatric care in Western Kentucky and stated his experience indicated that private practitioners do not lose a great number of patients to the health department clinics. In fact, quote: "Quite the contrary, as 'all' indigent patients do remain indigent." It was reiterated at this meeting that any clinics established should be kept on a strictly indigent basis. Doctor Fraser asserted that this would be included in the local agreement. Apparently, in most of the clinics, the paying patients are eventually weeded out and only the truly indigent remain. It was stated that the Eastern Kentucky clinics have the complete indorsement of the local medical societies and boards of health. All patients are referred by physicians or in some cases school teachers through physicians.

It would appear to us that as long as such care is maintained on an *indigent basis* and *under local physicians' referral,* it will be a valuable contribution to the health and welfare of our unfortunate children in Kentucky and a step toward lowering the infant mortality rate.

William C. Durham, M.D.
Representative

Recommendations, Reference Committee No. 7

Our committee has studied carefully the detailed report of the studies of this committee, and was impressed with the efforts that are being made to extend treatment centers and clinics in this important field. We feel recognition should be made of the time and talent donated by practicing physicians, especially in the care of indigent cases under local physician's reference.

Mr. Speaker, I move the adoption of this section of the report. (Motion seconded; carried.)

Our committee was impressed by the completeness of the reports reflecting the great effort expended in accomplishing the assigned duties by all the committees whose reports it studied.

Mr. Speaker, I move the adoption of the Report of Reference Committee No. 7 as a whole. (The motion was seconded and carried.)

I wish to thank the following members who served on this committee.

Reference Committee No 7
L. F. Beasley, M.D., Franklin, Chairman
Hylan Woodson, M.D., Greenville
Charles E. Peck, M.D., Russell Springs
W. B. Haley, M.D., Paducah
J. M. Stevenson, M.D., Brooksville

Unfinished Business

Doctor Sweeney noted that there was no unfinished business. He expressed appreciation for the spirit of cooperation and the good will of the delegates.

Election of Officers

The Speaker called for the report of the Nominating Committee, which was presented by its chairman, J. Sankey Williams, M.D. Nicholasville. Doctor Williams read the following list of nominations for the positions to be filled as follows.

President-Elect	Everett H. Baker, M.D., Louisville
Vice-Presidents	
Central	Robert W. Lykins, M.D., Louisville
Eastern	Harold B. Barton, M.D., Corbin
Western	Kenneth M. Eblen, M.D., Henderson
AMA Delegate	J. Thomas Giannini, M.D., Louisville
AMA Alternate Delegate	Charles G. Bryant, M.D., Louisville

After each nomination was presented, the Speaker called for nominations from the floor. The only nomination received from the floor was the name of B. H. Warren, M.D., Owensboro, for the office of Western Vice President. For each office other than the office of Western Vice President, each nominee was elected individually without dissent. The tellers counted the ballots for the contested office and Kenneth M. Eblen, M.D., Henderson, was declared elected vice president from the western district.

Doctor Williams then submitted the following nominations to the office of trustee:

Second District	W. Gerald Edds, M.D., Calhoun
Seventh District	Donald Chatham, M.D., Shelbyville
Ninth District	Mitchel B. Denham, M.D., Maysville
Tenth District	Douglas E. Scott, M.D., Lexington
Thirteenth District	Walter L. Cawood, M.D., Ashland

The same procedure followed in electing the general officers was followed in the election of the trustees. Since there were no nominations from the floor, the above-named nominees were elected.

Doctor Baker, the new President-Elect, was escorted to the rostrum. He received a standing ovation.

Nominations for Board of Directors, Kentucky Physicians Mutual, Inc.

The following list of nominees for the Board of Directors, Kentucky Physicians Mutual, Inc., was submitted and received for information only:

George P. Archer, M.D., Prestonsburg
Branham B. Baughman, M.D., Frankfort
Charles J. Bisig, M.D., Louisville
A. L. Cooper, M.D., Somerset
G. Y. Graves, M.D., Bowling Green
William W. Hall, M.D., Owensboro
O. Leon Higdon, M.D., Paducah
C. Charles Hugan, Jr., M.D., Covington
Max D. Klein, M.D., Shelbyville
W. K. Massie, M.D., Lexington
Carlisle Morse, M.D., Louisville
Earl P. Oliver, M.D., Scottsville
George W. Pedigo, Jr., M.D., Louisville
W. Vinson Pierce, M.D., Covington
R. W. Robertson, M.D., Paducah
Charles C. Rutledge, M.D., Hazard
Fred A. Scott, M.D., Madisonville
Charles B. Stacy, M.D., Pineville
Russell E. Teague, M.D., Frankfort
Leslie H. Winans, M.D., Ashland

Election of 1964 Nominating Committee

The nominating committee to serve at the 1965 Annual Meeting was elected as follows:

Harold B. Barton, M.D., Corbin
Carl H. Fortune, M.D., Lexington
Russell L. Hall., M.D., Prestonsburg
James M. Riley, Jr., M.D., Louisville
Paul J. Sides, M.D., Lancaster

Delmas M. Clardy, M.D., Hopkinsville was installed as president. The oath of office was administered by the Chairman of the Board of Trustees, Douglas E. Scott, M.D. President Clardy presented the past president's key to the retiring president, George P. Archer, M.D., Prestonsburg.

In his inaugural remarks, the new president discussed the KMA oath of office as is currently written and offered some thoughts on how it might be appropriately revised.

Doctor Sweeney thanked the members of the House of Delegates for their cooperation during both sessions. The second session of the 1964 House of Delegates was adjourned at 11:15 p.m.

March 18, 1965

is the date to remember

for the

KMA Interim Meeting

Gabe's Motor Inn **Owensboro, Ky.**

ORGANIZATION SECTION

1965 KMA Interim Meeting Set For March 18 at Owensboro

Plans for the 1965 KMA Interim Meeting, to be held in Owensboro on Thursday, March 18, are virtually complete, Delmas M. Clardy, M.D., KMA president and chairman of the Interim Meeting Program Committee, has reported.

Following the meeting of the Program Committee in Owensboro on November 19, Doctor Clardy announced that excellent speakers of national stature had been or were being committed for the meeting.

Austin Smith, M.D., president of the Pharmaceutical Manufacturers' Association and former editor of the Journal of the American Medical Association, whose speaking talents are in universal demand, will be featured as the luncheon speaker.

Important topics to be covered at the meeting include comments on the situation in Washington, new developments in prepayment, medicine's interest in area-wide hospital planning, and improvement in relations with allied groups.

Doctor Clardy said that full details will appear in subsequent issues of The Journal. The meeting will be held at Gabe's Restaurant and Motor Inn at Owensboro, and suggested that early reservations be made.

Fifth District to Meet Jointly With Fourth and Seventh

The Fifth Trustee District will play host to members of the adjoining Fourth and Seventh Districts at an important and informative meeting December 17 at the Medical Arts Building in Louisville, according to Alfred O. Miller, M.D., Louisville, Fifth District Trustee, who is in charge of arrangements.



Doctor Weston

Jean K. Weston, M.D., director of the department of drugs of the American Medical Association, will be the featured speaker of the evening. Sharing the spotlight with Doctor Weston will be Delmas M. Clardy, M.D., Hopkinsville, president of KMA, who will speak on the topic, "Your State Association."

Doctor Weston will present a discussion of the AMA's new drug testing program and the many ways in which the program will protect the public and serve the medical profession. He holds a Ph.D. degree from the University of Michigan and an M.D. degree from Temple.

A former laboratory director in experimental pathology and toxicology and former director of the department of clinical investigation for Parke, Davis and Company, Doctor Weston has also served as director of medical affairs for Burroughs Wellcome and Company.

Ky. Physicians' Mutual Board Elects Dr. Rust President

Richard J. Rust, M.D., Newport, was elected president of the Board of directors of Kentucky Physicians' Mutual (Blue Shield Plans in Kentucky) at the annual meeting of the Board on November 5 in Louisville.



Doctor Rust

Doctor Rust, a surgeon, was for many years chairman of the Medical Advisory Committee to the Board of Kentucky Physicians' Mutual and was one of the early members of the Board. He has held numerous committee appointments within KMA and has been active in the medical and civic affairs of his community.

Garnett J. Sweeney, M.D., Liberty, speaker of the KMA House of Delegates, and Robert W. Robertson, M.D., Paducah, past president of KMA, were elected vice-presidents of the Board at the November 5 meeting. B. B. Baughman, M.D., Frankfort, a member of the State Board of Health, was re-elected treasurer.

J. P. Sanford, Louisville, executive secretary of KMA, was re-elected secretary of the Board, and D. Lane Tynes, Louisville, was re-elected to the post of executive director. Mr. Tynes is executive director of Blue Shield and president of Blue Cross.

A readership questionnaire designed to gather significant opinions from you, our readers and members, about your KMA Journal, will be published in the January, 1965 issue of The Journal. An evaluation of your likes and dislikes will be of great value to us in formulating plans for the future. You are urged to watch for this questionnaire in The January Journal and to voice your opinion at that time.

The Editors

Ky. Assn. of Registered Nurses Elects Mrs. Nadine Turner

Mrs. Nadine Turner, director of nursing at the Murray-Calloway County Hospital, was elected president of the Kentucky State Association of Registered Nurses at the 1964 annual meeting of the Association in Louisville October 14-16.



Mrs. Turner

Mrs. Turner, who received her nursing degree from Norton Memorial Infirmary in Louisville, also holds a B.S. Degree in nursing from Vanderbilt University School of Nursing in Nashville.

Among the highlights of her nursing career have been posts at nursing schools in Texas, Illinois, and Kentucky. Mrs. Turner was director of nursing at Muhlenberg Community Hospital in Greenville before going to Murray.

Also elected at the October meeting of the association were the following new officers: Mrs. Kathryn Koon, Hopkinsville, second vice-president; Miss Lillian Shacklette, Louisville, treasurer; and Miss Agnes C. Hinman, Lexington and Sister Agnes Miriam, Louisville, directors.

Ky. Pair Take Part In Congress On Mental Health at Chicago

Beverly T. Mead, M.D., Lexington, assistant professor of psychiatry at the University of Kentucky Medical Center, and Robert G. Cox, KMA executive assistant, had key roles in the AMA Second National Mental Health Congress in Chicago November 5-7.

Doctor Mead was co-chairman of a workshop session concerning the enlistment of community support in rural areas.

Mr. Cox addressed participants in two workshops. His subjects were, "The Role of the County and State Medical Society in the Mental Health Movement", and "The Role of the Private Practitioner in Mental Health in Rural Areas".

Correction

The Journal regrets an unfortunate error in the Case Discussion heading on page 871 of the November issue. The discussion, entitled "Eclampsia: A Case Report", by John L. Duhring, M.D., and Donald Edger, M.D., both of the University of Kentucky College of Medicine, originated at the U.K. Medical Center, and *not* from the University of Louisville, as stated in the headline.



Doctor Harbison



Doctor Seeley

Norton Postgraduate Seminar Set Dec. 17 in Louisville

An excellent scientific postgraduate program, featuring two outstanding guest speakers, has been planned for the Seventh Annual Norton Memorial Infirmary Seminar December 17, according to Robert Lich, Jr., M.D., program chairman. The Seminar, to be held at Norton, will be co-sponsored by the Kentucky Academy of General Practice.*

Samuel T. Harbison, M.D., professor of surgery and associate dean of the University of Pittsburgh School of Medicine, will read papers on "Routinism, Iatrogenics and Surgical Care", and "An Evaluation of Recent Surgical Thinking".

William C. Sheldon, M.D., of the department of pediatric cardiology and the cardiac laboratory at Cleveland Clinic will provide another highlight of the program with two motion pictures, "The Cine Cardioangiography of Acquired Valve Disease", and "Cine Coronary Arteriography", Doctor Lich said.

E. C. Seeley, M.D., London, president of the KAGP, and Ludwig H. Segerberg, M.D., president of the Norton medical staff, will serve as presiding officers of the day-long program. The Seminar will also feature the presentation of nine other papers by faculty members of the University of Louisville School of Medicine.

Primarily directed toward the physicians of the Kentucky and Southern Indiana areas, the Seminar is open to all physicians who care to attend.

**Category I Credit applied for.*

Perry County Report is First

The Perry County Medical Society has the distinction of being the first County Society to report its 1965 officers roster to the Kentucky Medical Association. The report was sent by Charles C. Rutledge, M.D., Hazard, secretary.

Ralph Westervelt, M.D., will serve the society as president for the coming year. Also named were John F. Gilbert, M.D., vice-president; E. S. Carter, M.D., delegate to KMA; and Mary Pauline Fox, M.D., alternate delegate. Doctor Rutledge will serve as secretary and treasurer. He is also an alternate delegate from KMA to the AMA. The Perry County officers, all from Hazard, will take office January 1.

Dr. Cotthoff Elected Chairman of Ky. Rural Health Council

John E. Cotthoff, M.D., Hopkinsville, was elected chairman of the Kentucky Rural Health Council at a Council meeting following the Kentucky Rural Health Conference at the University of Kentucky Medical Center October 22.

"Health Careers" was the theme of the 12th annual conference, sponsored by the Rural Health Council. Delmas M. Clardy, M.D., Hopkinsville, president of KMA, was featured on the program, bringing greetings from the Kentucky Medical Association.

William R. Willard, M.D., dean of the U.K. College of Medicine and vice-president for the Medical Center, presented a thought-provoking talk on employment needs in the health field. Also on the program was Samuel Evans, Kentucky community employment program supervisor, who spoke on the employment and manpower situation in Kentucky.

Miss Deanna McLean, Kentucky Dairy Princess from Little Mount in Spencer County, served milk to the group during a break in the program. Miss McLean represented the American Dairy Association in Kentucky.

Robert L. Johnson, director of State and Local Services for the U.K. Medical Center, who served as program chairman for the Conference, was elected vice-chairman of the Council. William Padon, of the Kentucky Farm Bureau Federation, was re-elected secretary.

Ky. Medical Assistants Attend National Meeting Oct. 13-18

Seven representatives of the Kentucky State Association of Medical Assistants attended the eighth annual meeting of the American Association of Medical Assistants in Oklahoma City October 13-18, according to Miss Dorothy Downs, Louisville, KSAMA president and a delegate to the national meeting.

Attending with Miss Downs were delegates Mrs. Phoebe Faust and Mrs. Wanda Taylor, both of Louisville, and four alternate delegates: Mrs. Ernestine Gates, Mrs. Louise Hawkins, Miss Libby Curtsinger, and Mrs. Virginia Applegate, president of the Jefferson County Medical Assistants.

At its House of Delegates meetings the AAMA pledged organizational support and assistance to the American Medical Association in all legislative matters pertaining to the practice of medicine as a free enterprise. The House also went on record as endorsing the objectives of the American Medical Political Action Committee. The meeting had a record registration of 488.

New AMA Field Representative For Ky. is State Native

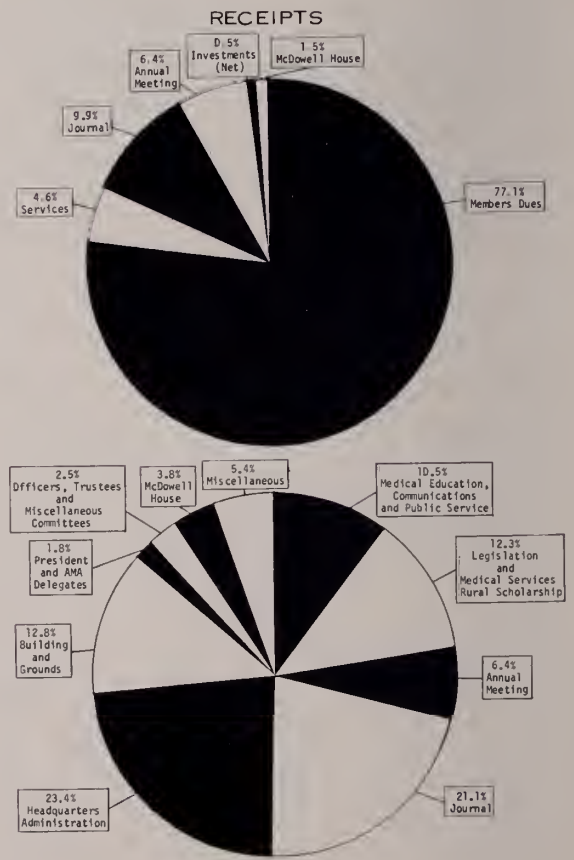
Harry R. Hinton, Chicago, a native Kentuckian and former administrator of Hazelwood Sanitorium in Louisville, has been assigned to cover Kentucky as field representative for the American Medical Association, Aubrey D. Gates, director of the AMA Division of Field Service, announced recently.

William R. Ramsey, who held this post for the past several years, has been named assistant director of the Division of Field Service. Mr. Hinton, who took over the Kentucky assignment November 1, will also cover Ohio, Pennsylvania, and West Virginia.

Mr. Hinton, a native of Sturgis, is known to a number of Kentucky physicians through his work in the Kentucky Junior Chamber of Commerce while in Louisville, and as administrator of Hazelwood.

Graphs Depict Distribution Of KMA Finances

Sources of income and the way its funds are disbursed by KMA are shown on the pie-shaped graphs below. These graphs, prepared by the Association's auditors, are based on the 1963-64 fiscal year. If members have any questions, they are urged to contact the headquarters office.





The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

In Diverticulosis and Diverticulitis...

METAMUCIL® brand of psyllium hydrophilic mucilloid

"Diverticulosis ... a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

"Diverticulitis Mild, chronic symptoms of diverticulitis, such as diarrhea or flatulence also are treated[1] by low-roughage diet, adequate fluid intake and Metamucil...."

Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

Research in the Service of Medicine



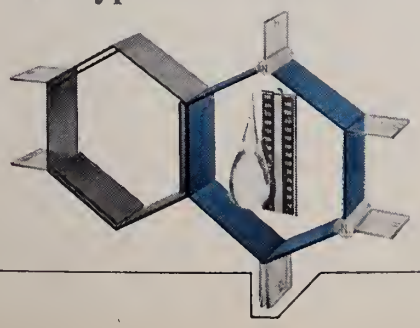
Just turned hypertensive

A 15 mm. Hg drop in diastolic pressure would also suit her very well

For suitably gradual, physiologic hypotensive treatment



HYDROMOX®
QUINETHAZONE-TABLETS
antihypertensive diuretic



HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

Lederle

8370-4

Medical School News

U.L. Accepts Gifts and Grants of $282,582 for Med. School

In a recent meeting the University of Louisville Board of Trustees voted to accept gifts and grants to the School of Medicine totaling $282,582 for research, scholarships, and other areas of need.

Following are a list of the recipients, amount of grant or gift, and the donor:

Steven Vandenburg, M.D., $82,365; Jose A. Zadunaisky, M.D., $24,561; Ulrich Westphal, Ph.D., $20,492; Kenneth McConnell, M.D., $18,764; K. C. Huang, M.D., $17,733; Frederick Hilton, M.D., $17,-251; Joseph Gennaro, M.D., $16,813; James Rogers, M.D., $11,138; and Frank Falkner, M.D., $6,465—a total of $215,582, all from the U.S. Public Health Service.

C. Dwight Townes, M.D., received a $25,500 grant from Research to prevent Blindness; Robert J. Kaiser, M.D., $3,300 from the National Society for Prevention of Blindness; and $3,000 to Leonard Berman, M.D., from Lloyd Brothers pharmaceutical manufacturers.

The new radiation center operated by the department of radiology received $20,000 from the Kentucky Division of the American Cancer Society; and the department of medicine was given a $6,000 grant-in-aid by Ayerst Laboratories; Commonwealth Life Insurance Company gave $3,500 for research in allergy and immunology.

Mrs. Dann C. Byck of Louisville gave the department of pediatrics 24 shares of Sears, Roebuck and Company common stock to continue the Dann C. Byck Fellowship in Pediatrics. An anonymous donor contributed $500 to establish an annual prize in pharmacology in the School of Medicine.

Faculty Appointments and Changes

The Board of Trustees at the October meeting also approved the following changes and appointments among School of Medicine faculty members:

Appointment of Bernard Schneider, M.D., as clinical instructor of obstetrics and gynecology; appointment of William Woodward Nicholson, M.D., as professor emeritus of pediatrics; promotion of Dorothy Shipe, Ph.D., to assistant professor of pediatrics; and promotions of Maurice T. Fliegelman, M.D., and Paul Mapother, M.D., to associate clinical professors of dermatology in the department of medicine.

Additional appointments were listed for the following:

Angelo A. Ciliberti, assistant professor of medicine, as associate in microbiology; Leonard B. Berman, M.D., associate professor of medicine, as associate in physiology; Jose A. Zadunaisky, M.D., associate professor of ophthalmology, as associate in physiology. The Board also voted tenure for Gaspar Carrasquer, M.D., associate professor of medicine and associate in physiology.

U.K. Med. Center Names New Orthopedic Surgery Chief

Thomas D. Brower, M.D., has been named new professor and chief of the section of orthopedic surgery at the University of Kentucky Medical Center, according to a recent announcement.

Doctor Brower, who graduated in 1947 from the Washington University School of Medicine in St. Louis, was associate professor of orthopedic surgery at the University of Pittsburgh School of Medicine before coming to Lexington.

Peter P. Bosomworth, M.D., chairman of the U.K. department of anesthesiology, and Lester R. Bryant, M.D., associate professor of surgery, presented a paper on "Physiologic Responses to Aspiration of Gastric Juices" at the 1964 annual meeting of the American Society of Anesthesiologists at Bal Harbour, Fla., October 12.

Cell Biology Department Approved

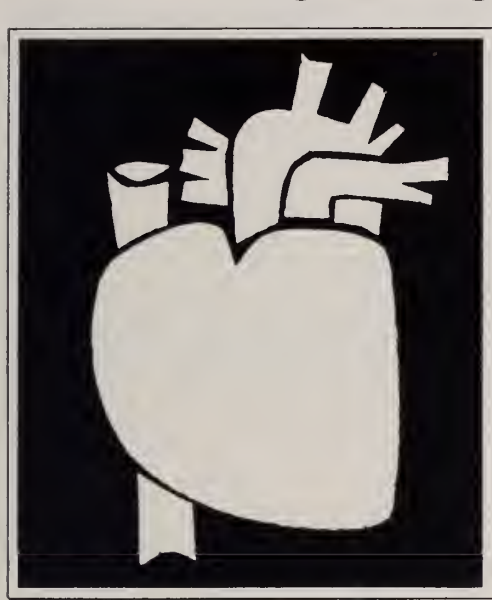
Establishment of a department of cell biology in the University of Kentucky medical and dental colleges was recently approved by the U.K. Board of Trustees. Richard S. Schweet, Ph.D., was named chairman of the department.

A dormitory for nursing students was dedicated October 25 at the University of Kentucky Southeastern Center at Cumberland, where young women participating in the Appalachian Regional Hospitals' professional nursing program will study for one year before completing the three-year course at the ARH Nursing School in Harlan. The school is operated by the Harlan ARH Hospital.

Dr. Simpson Honored

Gaithel L. Simpson, M.D., Greenville, past president of KMA, received the Conservation Award of Merit at the fourth annual Conservation Congress in Louisville in October. The awards are presented annually for outstanding work in promoting good conservation practices. Doctor Simpson is chairman of the Pond River Conservation District. KMA awarded Doctor Simpson its Distinguished Service Medal in 1964.

A CONSERVATIVE Rx FOR A CLASSIC Dx



SUDDEN ONSET
ANTERIOR
VAGUE IN CHARACTER
EFFORT
SUBSTERNAL

MILTRATE®

meprobamate 200 mg. + pentaerythritol tetranitrate 10 mg.

Effective tranquilization
plus
long-acting coronary vasodilation
for
prophylaxis of pain in angina pectoris

Indications: 'Miltrate' is useful for prophylaxis of pain in angina pectoris and coronary insufficiency, especially where anxiety is a factor. **Contraindications:** Like all nitrates, pentaerythritol tetranitrate should be avoided or prescribed cautiously for patients with glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** *Meprobamate* — Patients engaged in activities requiring alertness should be warned of drowsiness. Meprobamate may increase the effects of excessive alcohol, and the possibility of dependence should be considered, particularly in patients with a history of drug or alcohol addiction. Sudden withdrawal may result in reactions, rarely epileptiform seizures. Grand mal attacks may be precipitated in persons susceptible to both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies. **Side effects:** *Pentaerythritol tetranitrate* — The most common side effects are transient headache, nausea, and rash. Weakness, palpitation, flushing, gastrointestinal distress, and lightheadedness have been reported on a few occasions. *Meprobamate* — May cause drowsiness and, rarely, ataxia, usually controlled by decreasing the dosage. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions include urticarial or maculopapular rash. Serious reactions, rarely encountered, include dermatological effects, acute nonthrombocytopenic purpura, chills, fever, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crisis, anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic, and the drug not be reinstituted. **Dosage:** Usual dosage is one or two tablets before meals and at bedtime. Individualization of dosage is required for maximum therapeutic effect. Doses above twelve tablets daily are not recommended. **Supplied:** White tablets, each containing meprobamate 200 mg. and pentaerythritol tetranitrate 10 mg.
Before prescribing, consult package circular.

WALLACE LABORATORIES / Cranbury, N. J.

CML-4087

"My colleagues thought I was crazy!"

Nick Cunningham, M.D., was eminently qualified for any number of promising medical posts here at home. Harvard pre-med. Hopkins medical. London's Guys Hospital. New York's Presbyterian Hospital.

Yet, with this rich professional background, Nick Cunningham chose to become one of the first volunteer doctors in the Peace Corps.

He preferred to go to an African nation where there is one physician



for every 80,000 people. Where modern medicine is all but unknown. Where the most stubborn clinical problems exist. Cholera, trachoma, encephalitis, leprosy and a horde of other debilitating diseases.

And for his two-year stretch as a Peace Corps doctor, Nick Cunningham's pay was only $75 a month — plus living expenses. One reason why his colleagues called him crazy.

But Dr. Cunningham saw and realized other compensations in his Peace Corps assignment. A chance to take the best in American medicine to a country desperately needing it. A rare opportunity for professional, cultural and personal growth.

If you've some of the spirit and dedication of Nick Cunningham, the Peace Corps needs you. There are many more requests from nations around the world than doctors to fill them.

If you think you could tackle one of the most challenging and rewarding openings in medicine today, get in touch with us.

Write: THE PEACE CORPS, Washington, D.C. 20525.

Published as a public service in cooperation with the Advertising Council.



McDOWELL HOUSE VISITORS, representatives of the Cincinnati Medical History Society, are shown in the living room of the famous old home in Danville, which they visited October 15. From left are Cecil Striker, M.D., president of the Society; Mrs. Striker; Julien Benjamin, M.D.; George Grider, Danville, curator of the McDowell House; and John Braunstein, M.D.

Cincinnati Medical Historians Tour McDowell House

Boyle County Medical Society members and their wives played host October 15 to wives and members of the Cincinnati Medical History Society at McDowell House in Danville, where the group climaxed a tour of central Kentucky medical/historical sites.

The Cincinnatians, headed by Cecil Striker, M.D., president of the Society, were entertained at a tea in the McDowell Home by local physicians and Medical Auxiliary members. Also on hand for the event were Miss Estelle Crawford, official hostess of McDowell House, and George Grider, Danville pharmacist and curator of the House and Shop.

Among other spots on the History Society's tour program were Transylvania College Library at Lexington, where the McDowell collection is housed, and the John Hunt Morgan House in Lexington.

U. of L. Sets Ten-Week Course Electrocardiography

A ten-week Postgraduate Course in Electrocardiographic Interpretation is scheduled to open Wednesday night, January 6, 1965 at the Louisville General Hospital under the sponsorship of the University of Louisville Medical Center. The sessions will be held from 7 to 9 p.m. each Wednesday through March 10.

The fee for practicing physicians is $35.00. Preliminary registration should be directed to the Dean's Office, University of Louisville School of Medicine. The course has been submitted to the Kentucky Chapter of the American Academy of General Practice for Category I credit.

Speakers for the course, all from the University of Louisville School of Medicine, are Maurice Best, M.D., Associate Professor of Medicine; Herbert L. Clay, M.D., Associate Professor of Medicine; Walter S. Coe, M.D., Associate Clinical Professor of Medicine; Ralph Denham, M.D., Instructor in Medicine; Charles H. Duncan, M.D., Associate Professor of Medicine; and

Topics for the course have been announced as follows:

January 6: "Introduction, Theory and Basic Principles of Electrocardiography"; Dr. Clay and Dr. Best.

January 13, 20 and 27: "Development of Simple Vectoral Analysis Method of Interpretation and Slide Demonstrations"; Dr. Clay and Dr. Best.

February 3: "Review of Vectoral analysis Method and Discussion of Digitalis Effect with Slide Demonstrations"; Dr. Clay and Dr. Coe.

February 10: "Sinus Rhythm Disturbances and Ectopics" and "Av Conduction Defects"; Dr. Denham and Dr. Coe.

February 17: "Atrial and Nodal Rhythm Disturbances" and I.V. Conduction Defects"; Dr. Denham and Dr. Coe.

February 24: "Ventricular Rhythm Disturbances" and "Quinidine, Potassium and Calcium Effects and Electrocardiogram"; Dr. Denham and Dr. Best.

March 3: "Effects of Exercise on Electrocardiogram" and "Effects of Emotional States on Electrocardiogram"; Dr. Denham and Dr. Duncan.

March 10: "Review"; all speakers.

Jeff. Society Honors 21

The Jefferson County Medical Society at its November 16 meeting honored 21 former presidents, six of whom have also been presidents of the Kentucky Medical Association. Each of the group was presented with an engraved gavel at special ceremonies during the regular meeting at the Medical Arts Building.

NEWS ITEMS

Larry B. Craycraft, M.D., and **Dorval H. Donahoe, M.D.,** have announced the opening of their office in Catlettsburg, where they will have a general practice. Both are 1963 graduates of the West Virginia University College of Medicine and both interned at Mercy Hospital in Springfield. Doctor Donahoe and Doctor Craycraft are natives of West Virginia.

Francis J. Dillard, M.D., has become associated with the Fuller-Morgan Clinic at Mayfield, it was recently announced. An internist, Doctor Dillard graduated in 1949 from the Medical College of Virginia and interned the following year at Geisinger Memorial Hospital at Danville, Pa. He was a resident at the Veterans Administration Hospital in Richmond.

Thomas F. Plaut, M.D., Whitesburg, a 1959 graduate of Columbia University College of Physicians and Surgeons, has become associated with the Daniel Boone Clinic, it was recently announced. Doctor Plaut, a pediatrician, interned in pediatrics at Bellevue Hospital, New York City, and completed his residency at the same hospital.

James V. Grief, M.D., Covington, has become associated with **Maurice R. Walsh, M.D., Norman Adair, M.D., Morris M. Garrett, M.D.,** and **W. Donald Janney, M.D.,** at Covington, for the practice of radiology. Doctor Grief, a 1960 graduate of Indiana University School of Medicine, interned at Polk County Hospital, Des Moines, Iowa, and completed his residency at the Indiana University Hospital.

Robert E. Robbins, M.D., has started practice at Greenville in the offices of **Gaithel L. Simpson, M.D.,** and **George H. Rodman, M.D.** A surgeon, Doctor Robbins graduated in 1958 from the University of Cincinnati College of Medicine and interned at St. Mary's Hospital in Cincinnati. His residency requirements were completed at the University of Louisville hospitals.

Clyde T. Moore, M.D., and **Robert J. Lehman, M.D.,** both of Louisville, were elected in the November 3 general election to terms on the Boards of Education of Louisville and Jefferson County. Doctor Moore was reelected for his second four-year term on the Jefferson County Board, and Doctor Lehman was newly elected for four years on the City Board.

Wellington B. Stewart, M.D., professor and chairman of the department of pathology at the University of Kentucky Medical Center, has been named chairman of the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists.

Paul C. Grider, Jr., M.D., Louisville, is now associated with **George W. Pedigo, M.D.,** for the practice of internal medicine. Before completing his internship and residency at Parkland Memorial Hospital in Dallas, Doctor Grider graduated in 1958 from the University of Louisville School of Medicine.

M. C. Blaydes, M.D., Lexington, is practicing internal medicine in association with the Lexington Clinic, it was recently announced. Doctor Blaydes, who graduated in 1954 from the University of Virginia College of Medicine, interned at Strong Memorial Hospital, Rochester, New York, and was a resident there and at the University of Virginia Hospital.

Lewis E. Martin, M.D., has started general practice at Adairville, according to recent announcement. He is a 1963 graduate of the University of Louisville School of Medicine, and interned at Mercy Hospital in Springfield, Ohio. Doctor Martin previously practiced for a short time at Cadiz.

John F. Gilbert, M.D., Hazard, has announced the opening of his office in that city, where he will practice general medicine. Doctor Gilbert graduated from the University of Louisville School of Medicine in 1963 and interned at the University of Kentucky Medical Center.

County Society Reports

McCracken

F. Y. Clare, M.D., Louisville, presented the scientific program on the subject of "Eradication Program for Syphilis in the United States" at the September 23 meeting of the McCracken County Medical Society at Boswell's restaurant in Paducah. O. D. Maxey, M.D., Paducah, president, presided at the meeting.

A letter was read regarding the establishment of a sheltered workshop for the mentally retarded and handicapped adults in the Paducah area. A donation of any size was requested. It was pointed out that the balance of money left over from the polio drive was donated for this purpose.

Society participation in the nation-wide educational program sponsored by the AMA was discussed and agreed upon.

The Board of Censors accepted and approved the applications of two new members.

The Society went on record as approving the sewerage program for the city.

The meeting adjourned at 9:10 p.m.

McCracken

M. Edward Davis, M.D., professor of obstetrics and gynecology at the Chicago Lying-In Hospital, was our distinguished guest for the October 28 meeting of the McCracken County Society held at Boswell's Restaurant. O. D. Maxey, M.D., Paducah, president, presided at the meeting.

Doctor Davis presented the scientific program for the evening on the topic, "Estrogens and Retardation of Aging in Women."

The Society voted to extend an invitation to all regular meetings to all members of the First Trustee District. This is to be done on a routine basis.

A nominating committee was appointed by Doctor Maxey to propose a slate of officers at the December meeting. The meeting adjourned at 9:25 p.m.



ACHROCIDIN®

TETRACYCLINE HCl-ANTIHISTAMINE-ANALGESIC COMPOUND

Each Tablet contains:

ACHROMYCIN® Tetracycline HCl	125 mg.	Caffeine	30 mg.
Acetophenetidin (Phenacetin)	120 mg.	Salicylamide	150 mg.
		Chlorothen Citrate	25 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms. Tooth discoloration may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Reduce dosage in impaired renal function. Average Adult Dosage: 2 Tablets four times daily.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

8265-4

Continuing Educational Opportunities

From The

KMA Postgraduate Medical Education Office

IN KENTUCKY

DECEMBER

17 — 7th Annual Post Graduate Medical Seminar, Sponsored by Norton Memorial Infirmary & Kentucky Chapter American Academy of General Practice, Norton Memorial Infirmary, Louisville

17 — University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington

17 — KMA Joint Trustee District Meeting, 4th, 5th and 7th Districts, Dinner Meeting, Medical Arts Building, Louisville

JANUARY

7 — "Professor's Day", 9:00 a.m. to 3:00 p.m., University of Kentucky Medical Center, Lexington

6, 13, 20, 27 — "Electrocardiographic Interpretation": 7:00 p.m. - 9:00 p.m. (Wednesday evenings), University of Louisville Medical Center, Louisville

14 — Pediatrics, "Refresher Course", 8:00 a.m.-5:00 p.m., University of Kentucky Medical Center, Lexington

21 — University Surgery Day, 12:00-5:00 p.m., University of Kentucky Medical Center, Lexington

29 — "Cardiology Night": 7:30 p.m. - 9:00 p.m., University of Kentucky Medical Center, Lexington

FEBRUARY

3, 10, 17, 24 — "Electrocardiographic Interpretation": 7:00 p.m. - 9:00 p.m., (Wednesday evenings), University of Louisville Medical Center, Louisville

4 — "Professor's Day": 9:00 a.m. - 3:00 p.m., University of Kentucky Medical Center, Lexington

11 — Pediatrics, "Refresher Course": 8:00 a.m. - 5:00 p.m., University of Kentucky Medical Center, Lexington

18 — Medicine, "G. I. Diseases": 8:00 a.m. to 5:00 p.m., University of Kentucky Medical Center, Lexington

26 — "Cardiology Night": 7:30 p.m. - 9:00 p.m., University of Kentucky Medical Center, Lexington

MARCH

3 — "Electrocardiographic Interpretation": 7:00 p.m. - 9:00 p.m., (Wednesday evenings), University of Louisville Medical Center, Louisville

11 — Pediatrics, "Refresher Course": 8:00 a.m.- 5:00 p.m., University of Kentucky Medical Center, Lexington

11-12 — Hematology, University of Kentucky Medical Center, Lexington

18 — KMA Interim Meeting, Gabe's Motor Inn, Owensboro, Kentucky

26 — "Cardiology Night": 7:30 p.m. - 9:00 p.m., University of Kentucky Medical Center, Lexington

29-30 — Symposium on Genito-Urinary Disease, University of Kentucky Medical Center, Lexington

IN SURROUNDING STATES

JANUARY

9-14 — American Academy of Orthopaedic Surgeons, Americana Hotel, New York, New York

14 — Northern Kentucky Seminar, KAGP, Cincinnati, Ohio

20-22 — *Diabetes in Review: Clinical Conference, 1965,* Drake Hotel, Chicago, Illinois

25-27 — American College of Surgeons, Sectional Meeting, Atlanta Biltmore Hotel, Atlanta, Georgia

25-27 — Society of Thoracic Surgeons, Chase-Park Plaza Hotel, St. Louis

29-31 — Southern Radiological Conference, Grand Hotel, Point Clear, Ala.

FEBRUARY

5-10 — Congress on Medical Education, Palmer House, Chicago, Illinois

25-March 2 — American Dermatological Association, Boca Raton Hotel, Boca Raton, Florida

Dr. Witten on AMA Committee

As the Journal went to press it was learned that Carroll L. Witten, M.D., Louisville, delegate to the American Medical Association from the Section on General Practice, had been appointed to serve on the Reference Committee on Medical Education and Hospitals at the AMA interim meeting in Miami Beach November 29-December 2. The appointment was made by Milford O. Rouse, M.D., Dallas, speaker of the AMA House of Delegates.

Daviess County M.D.s Honored

Five Daviess County physicians were awarded silver loving cups at the October 27 meeting of the Daviess County Medical Society for their services rendered for the Daviess County Board of Public Health.

The Board honored William W. Hall, M.D., president of the Daviess County Medical Society; Anne Hopwood, M.D., county Health Officer; Thomas H. Milton, former Board member; W. H. Parker, M.D., former Health Officer; and William L. Woolfolk, M.D., former Board member. All are from Owensboro.

Retardation Unit Gets Director

JoAnne Sexton, M.D., Louisville, has been named to head the Mental Retardation Program of the Kentucky State Department of Health, according to a recent announcement by Helen B. Fraser, M.D., director of the division of Maternal and Child Health of the Department of Health.

Doctor Sexton, a pediatrician, will work with the Department of Health and the University of Louisville School of Medicine in carrying out the program. She is a 1957 graduate of the U. of L. School of Medicine and completed her residency at Children's Hospital. She also completed a one-year fellowship in pediatric neurology at Baylor University in Houston.

New National Society Formed

The American Academy of Facial Plastic and Reconstructive Surgery, Inc., was formed in Chicago October 18 through the merger of the American Otorhinologic Society for Plastic Surgery, Inc., and the American Society of Facial Plastic Surgery, Inc. The merger was approved by the membership of both groups.

The new medical society, expected to include approximately 700 physicians, will consist mainly of otolaryngologists who perform plastic and reconstructive surgery of the head and neck. It was formed with the assistance of the American Medical Association and the American Academy of Ophthalmology and Otolaryngology.



State officers and County presidents and presidents-elect of the KMA Woman's Auxiliary met November 10 in the Board Room of the KMA Headquarters office for their annual Fall Conference and Board of Directors' meeting. Seated from left to right are Mrs. Earl Roles, Louisville, co-editor of the Blue Grass News and a regional vice-president of the AMA Auxiliary; Mrs. John F. Ashworth, Ashland, Boyd County president; Mrs. J. Jack Martin, Tompkinsville, KMA Auxiliary president; Mrs. George P. Archer, Prestonsburg, state program chairman; and Mrs. Robert J. Salisbury, Mt. Sterling, president-elect of the state auxiliary. Herbert L. Clay, Jr., M.D., Louisville, gave an address before the group at the morning session.

Automotive Medical Group Meets

William K. Keller, M.D., Louisville president of the American Association for Automotive Medicine, presided over the 1964 Annual meeting of the association held October 26-27 in Louisville. Doctor Keller, chairman of the department of psychiatry at the U. of L. School of Medicine, completed his one-year term of office this year, and was succeeded by Joseph M. Janes, M.D., of the Mayo Clinic, Rochester, Minn.

Industrial Health Group to Meet

The 1965 American Industrial Health Conference will be held April 5-8 at the Americana Hotel, Miami Beach, Fla., it has been announced by the Industrial Medical Association and the American Association of Industrial Nurses. Further information about the Conference may be obtained by writing to the American Industrial Health Conference, 55 East Washington St., Chicago, Ill., 60602.

Nursing Home Group Elects

William Pierce, Louisville, was elected president of the Kentucky Association of Nursing and Personal Care Homes during the November 10-11 meeting of the group in Paducah.

Named first, second and third vice-presidents, in that order, were: Leon Kingsolver, Danville, Mrs. Mary Metzmeier, Campbellsville, and Alton Foster, Scottsville. Mrs. Helen Piper, Paducah, was elected secretary, and Elmer Schafner, Louisville, treasurer. At the same meeting, Mrs. Ann Stokes, Louisville, was installed as fourth regional vice-president of the national association.



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



Annual Report of the Kentucky Maternal Mortality Committee*

THIS is a report of maternal deaths that occurred in Kentucky for the years 1960-61-62. The following tables contain information obtained by the State Office of Biostatistics and by the Maternal Mortality Committee. Two sets of tables are included. The numbered tables (1, 2, 3, etc.) contain the statistical analyses of deaths recorded by the Office of Biostatistics. These figures are obtained in accordance with the International Classification of deaths and are therefore the figures on maternal mortality which are comparable with the statistics from other states and/or countries, because of the standardized procedure of classification used.

The numbered and lettered tables (1a, 2a, 3a, etc.) contain the statistical analyses of the deaths reported by the office of Biostatistics plus the study of additional deaths found by the Maternal Mortality Committee. This is so because in an effort to determine more correctly the actual number of deaths occurring in Kentucky, the Maternal Mortality Committee through the Maternal and Child Health Division of the State Department of Health began in 1960 to review all death certificates of females between 15-44 years of age. Many unrecorded maternal deaths were found in this way. These figures give us more realistic information of maternal deaths in the State of Kentucky, but cannot be used for comparative purposes. Nevertheless, to emphasize the importance of this new method of review of death certificates, these numbered and lettered tables with the corrected (unofficial) figures follow:

** Additional tables concerning maternal mortality in Kentucky will be published on the next regularly scheduled Maternal Mortality Page in the February issue of The Journal.*

TABLE 1—Maternol Deaths by Occurrence and Age from Biotatistics

	1962		1961		1960	
Age Group	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total — all ages	29	4.1	40	5.6	29	4.0
15 - 19	2	1.6	5	3.7	—	—
20 - 24	3	1.2	10	4.1	2	0.8
25 - 29	7	4.5	8	5.0	9	5.5
30 - 34	7	7.1	8	7.9	7	6.7
35 - 39	10	18.1	6	10.2	7	11.4
40 and over	—	—	3	15.6	4	19.9

TABLE 1o—Maternol Deaths by Occurrence and Age Group; from Committee Study

	1962		1961		1960	
Age Group	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total — all ages	42	5.9	50	6.8	41	5.6
15 - 19	3	2.3	7	5.2	3	2.3
20 - 24	4	1.7	12	5.0	3	1.3
25 - 29	12	7.7	11	6.9	13	8.0
30 - 34	8	8.2	9	8.9	10	9.5
35 - 39	15	27.2	7	11.9	7	11.4
40 and over	—	—	4	20.8	5	24.8

TABLE 2—Maternal Deaths by Occurrence, by Attendant, from Biostatistics

	Total		Physician		Midwife		Other		Not Stated
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths
1962	29	4.1	25	3.6	1	4.7	3	198.7	—
1961	40	5.5	33	4.7	3	13.4	4	272.1	—
1960	29	3.9	24	3.4	2	8.6	3	173.4	—

TABLE 2o—Maternol Deaths by Occurrence by Attendont, from Committee Studies

	Total		Physician		Midwife		Other		Not Stated
Year	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths
1962	42	5.9	38	5.5	1	4.7	3	198.7	—
1961	50	6.8	43	6.1	3	13.4	4	272.1	—
1960	41	5.6	35	4.9	2	8.6	3	173.4	1

In Memoriam

JAMES W. T. FULLER, M.D.
Mayfield, Ky.
1902 - 1964

James W. T. Fuller, M.D., 62, Mayfield surgeon, died October 29 enroute to a St. Louis Hospital for treatment of an accidentally inflicted gunshot wound. Doctor Fuller started practice in Mayfield in 1928 following his graduation in 1926 from the Eclectic Medical College of Cincinnati. The son of a Graves County physician, he saw active service in the U.S. Navy Medical Corps from 1942-46, and retired from the Navy in 1954 with the rank of rear admiral.

VIRGIL LEE POWELL, M.D.
Paducah, Ky.
1884 - 1964

Virgil Lee Powell, M.D., 80, Paducah general surgeon, died November 4 following a long illness. Doctor Powell, who had been in practice at Paducah since his graduation in 1910 from the Medical Department of the University of Louisville, had for more than 50 years been a surgeon for the Illinois Central Railroad. He was a member of a number of medical organizations, in which he took an active part.

WILLIAM PERRY HUMPHREY, M.D.
Sturgis, Ky.
1913 - 1964

William P. Humphrey, M.D., 51, died October 10 at Sturgis following a long illness. A 1942 graduate of the Louisiana State University School of Medicine, he had been in general practice at Sturgis from 1944 until his retirement due to ill health. Doctor Humphrey had been a member of the city council for many years in addition to other civic and medical activities. He was the son of the late Ben. F. Humphrey, M.D.

WILLIAM PROCTOR CAWOOD, M.D.
Harlan, Ky.
1883 - 1964

William P. Cawood, M.D., 81, retired Harlan County surgeon, died October 15 following a long illness. Doctor Cawood, who graduated in 1907 from the Medical Department of the University of Louisville, began practice at Evarts, then went to Harlan, where he had remained since. He was known widely for his interest and activity in politics and civic affairs. Doctor Cawood was a past president of the Harlan County Medical Society.

GILBERT ADAMS COOK, M.D.
North Middletown, Ky.
1879 - 1964

Gilbert A. Cook, M.D., 84, retired North Middletown general practitioner, died October 10 at Paris. Doctor Cook had practiced at North Middletown since his graduation from the Medical Department of the University of Louisville in 1905. He was an active church member and a 50 year Mason.

GEORGE PURDY, M.D.
New Liberty, Ky.
1879 - 1964

George Purdy, M.D., 85, Owen County general practitioner for 55 years, died October 16 at Peewee Valley following a long illness. Doctor Purdy, a 1904 graduate of the Medical Department at the University of Louisville, practiced at New Liberty from that time until his retirement in 1959. He had been active in local civic and church affairs and was a former president of the Citizens Bank of New Liberty.

ROBERT D. HIGGINS, M.D.
(Formerly) Ashland, Ky.
1894 - 1964

Robert D. Higgins, M.D., former Ashland Public Health Officer, died October 8 in New York City where he was attending a medical meeting. Doctor Higgins, who had practiced medicine in Ashland after his graduation from the University of Louisville School of Medicine in 1917 until 1941, had recently been practicing in association with the North Carolina Department of Health at Raleigh.

THOMAS A. PEASE, M.D.
(Formerly) Cunningham, Ky.
1887 - 1964

Thomas A. Pease, M.D., 77, retired general practitioner, died November 1 at his home in Chula Vista, Calif., where he had lived since 1959. Doctor Pease, who graduated in 1912 from the Eclectic Medical College of Cincinnati, practiced in Cincinnati until 1935, when he returned to his home at Cunningham to practice until 1959.

* * *

AMA Lecture Given at Morehead

I. Frank Tullis, M.D., professor of medicine and chairman of the department of medicine at the University of Tennessee, addressed Morehead State College students and faculty Monday, November 23, as a part of the AMA lecture series. Doctor Tullis spoke on "Body Changes During Weight Reduction of Obese Individuals".

U.C. Schedules Pediatric Course

"Pediatric Aspects of Surgery in Childhood" will be the topic of the second annual Postgraduate Course in Pediatrics to be held by the department of Pediatrics of the University of Cincinnati College of Medicine May 24 and 25, 1965. Registration will be limited to 50. A fee of $50 will be charged. Address all inquiries to William Schubert, M.D., The Children's Hospital, Cincinnati, Ohio, 45229.

Councils and Committees of the Councils, Standing and Miscellaneous Committees for the 1964-65 Associational Year

Council on Scientific Assembly

Delmas M. Clardy, M.D., Hopkinsville, Chairman
Everett H. Baker, M.D., Louisville, Vice-Chairman
Harvey Chenault, M.D., Lexington
Douglas M. Haynes, M.D., Louisville
Benjamin B. Jackson, M.D., Louisville
Clyde T. Moore, M.D., Fern Creek
Edmund D. Pellegrino, M.D., Lexington

Scientific Program Committee

Douglas M. Haynes, M.D., Louisville, Chairman
Harvey Chenault, M.D., Lexington
Delmas M. Clardy, M.D., Hopkinsville
Eugene H. Conner, M.D., Louisville
Nicholas J. Pisacano, M.D., Lexington
Ray J. Timmerman, M.D., Newport
J. Sankey Williams, M.D., Nicholasville

Golf Committee

James B. Douglas, M.D., Louisville, Chairman
Harold W. Baker, M.D., Louisville
Bernard J. Baute, M.D., Lebanon
Merle W. Fowler, Jr., M.D., Paducah
P. B. Hall, M.D., Paintsville
Edward G. Houchin, M.D., LaGrange
Kenton D. Leatherman, M.D., Louisville
D. Maurice Royalty, M.D., Lexington
Harvey B. Stone, M.D., Hopkinsville
Nathan Zimmerman, M.D., Louisville

Technical Exhibits Committee

Clyde T. Moore, M.D., Fern Creek, Chairman
Clyde M. Brassfield, M.D., Elizabethtown
Willett H. Rush, M.D., Frankfort
F. Norman Vickers, M.D., Louisville

Awards Committee

William H. Bizot, M.D., Louisville, Chairman
Neal Calhoun, M.D., Madisonville
Ollie B. Emerine, M.D., Elizabethtown
William O. Preston, M.D., Lexington
Richard H. Weddle, M.D., Somerset

Scientific Exhibits Committee

Benjamin B. Jackson, M.D., Louisville, Chairman
Howard E. Dorton, M.D., Lexington
Thomas R. Marshall, M.D., Louisville

Council on Medical Education and Hospitals

George A. Sehlinger, M.D., Louisville, Chairman
James B. Holloway, M.D., Lexington
Walter I. Hume, Jr., M.D., Louisville
Andrew M. Moore, M.D., Lexington
E. C. Seeley, M.D., London
Donn L. Smith, M.D., Louisville
William R. Willard, M.D., Lexington

Advisory Committee to the University of Kentucky

Andrew M. Moore, M.D., Lexington, Chairman
Harry C. Denham, M.D., Maysville
Carlisle V. Dodson, M.D., Russellville
Ben Eiseman, M.D., Lexington
Charles E. Rankin, M.D., Lexington
Harold D. Rosenbaum, M.D., Lexington

Advisory Committee to the University of Louisville

George A. Sehlinger, M.D., Louisville, Chairman
Roy H. Moore, M.D., Louisville
Rudolf J. Noer, M.D., Louisville
Alvin C. Poweleit, M.D., Covington
Beverly T. Towery, M.D., Louisville
George H. Widener, Jr., M.D., Paducah

Hospital Committee

James B. Holloway, M.D., Lexington, Chairman
Frank A. Bechtel, M.D., Louisville
James E. Bryan, M.D., Louisville
Lewis Dickinson, M.D., Glasgow
James A. Harris, M.D., Paducah
Erwin G. Heiselman, M.D., Newport
O. W. Thompson, Jr., M.D., Pikeville

General Practice Committee

E. C. Seeley, M.D., London, Chairman
James Douglas Adams, M.D., Prestonsburg
C. Walker Air, M.D., Ludlow
Howard I. Frisbie, M.D., Stanford
Charles B. Spalding, M.D., Bardstown
Norma T. E. Shepherd, M.D., Hopkinsville
William P. VonderHaar, M.D., Louisville

AMA-ERF Committee

Walter I. Hume, Jr., M.D., Louisville, Chairman
William E. Bakewell, M.D., Lexington
C. Melvin Bernhard, M.D., Louisville
Angelo A. Ciliberti, M.D., Louisville
Robert L. Houston, Jr., M.D., Eminence
James S. Rich, M.D., Lexington
Robert J. Salisbury, M.D., Mount Sterling

Council on Legislative Activities

John C. Quertermous, M.D., Murray, Chairman, National Affairs
James C. Cantrill, M.D., Georgetown, Chairman, State Affairs
B. B. Baughman, M.D., Frankfort
Hoyt D. Gardner, M.D., Louisville
Daryl P. Harvey, M.D., Glasgow
David B. Stevens, M.D., Lexington

Council on Medical Services

John A. Bishop, M.D., Jeffersontown, Chairman
L. F. Beasley, M.D., Franklin
James B. Douglas, M.D., Louisville
Logan Gragg, Jr., M.D., Lexington
Earl P. Oliver, M.D., Scottsville
George W. Pedigo, M.D., Louisville
Claude C. Waldrop, M.D., Williamstown

Insurance Committee

John A. Bishop, M.D., Jeffersontown, Chairman
Richard A. Allnutt, M.D., Covington
John L. Dixon, M.D., Owensboro
Paul E. Lett, M.D., Lancaster
Burton A. Washburn, M.D., Paducah
Joe S. Wheeler, M.D., Ashland
Lyle C. Franz, M.D., Maysville

Mental Health Committee

Logan Gragg, Jr., M.D., Lexington, Chairman
Earl J. Farrell, M.D., Ft. Thomas
Frank M. Gaines, M.D., Louisville
Hubert R. Holland, M.D., Paducah
Hollis Johnson, Jr., M.D., Louisville
John C. Keeley, M.D., Owensboro
Wilber A. Mitchell, M.D., Louisville
Joseph B. Parker, Jr., M.D., Lexington

Sub-Committee on Alcoholism

John C. Keeley, M.D., Owensboro, Chairman
Robert M. Blake, M.D., Maysville
E. M. Howard, M.D., Harlan
Charles W. Morris, M.D., Louisville
Gradie R. Rowntree, M.D., Louisville
Mary N. Smith, M.D., Danville

Advisory Commission to Blue Shield

W. Vinson Pierce, M.D., Covington, Chairman
Charles J. Bisig, M.D., Louisville
Charles O. Bruce, M.D., Louisville
Robert H. Cofield, M.D., Covington
James B. Douglas, M.D., Louisville
Richard F. Greathouse, M.D., Louisville
William W. Hall, M.D., Owensboro
James A. Holbrook, M.D., Prestonsburg
Walter R. Johnson, Jr., M.D., Paducah
James T. McClellan, M.D., Lexington
Robert L. McClendon, M.D., Louisville
William K. Massie, M.D., Lexington
W. Faxon Payne, M.D., Hopkinsville
Harvey R. St. Clair, M.D., Louisville
Ralph M. Scott, M.D., Louisville
Wellington B. Stewart, M.D., Lexington
William B. Stodghill, M.D., Louisville
Garnett J. Sweeney, M.D., Liberty
John C. Weeter, M.D., Louisville

Advisory Committee to Blue Cross

George W. Pedigo, M.D., Louisville, Chairman
David C. Asher, M.D., Pineville
Dwight L. Blackburn, M.D., Berea
Robert M. Blake, M.D., Maysville
James R. Dade, M.D., Hopkinsville
Richard F. Grise, M.D., Bowling Green
William C. Gose, M.D., Pikeville
James E. Hix, M.D., Owensboro
James B. Holloway, M.D., Lexington
Wilbur R. Houston, M.D., Erlanger
Walter I. Hume, Jr., M.D., Louisville
James M. Keightley, M.D., Harrodsburg
Esten S. Kimbel, M.D., Frankfort
C. C. Lowry, M.D., Murray
Harold B. McWhorter, M.D., Ashland
Sam A. Overstreet, M.D., Louisville
John J. Sonne, M.D., Bardstown

Physicians' Placement and Membership Committee

Claude E. Cummins, Jr., M.D., Maysville, Chairman
Madison J. Cawein, III, M.D., Lexington
C. C. Howard, M.D., Glasgow
Edward E. Landis, M.D., Louisville
Donald L. Martin, M.D., Ary
George F. McAuliffe, M.D., Louisville
C. J. Shipp, M.D., Greenville

Federal Medical Services Committee

L. F. Beasley, M.D., Franklin, Chairman
L. Douglas Atherton, M.D., Louisville
A. L. Goodman, M.D., Louisville
John P. Hill, Jr., M.D., Somerset
Walker M. Turner, M.D., Paducah
Thomas F. Whayne, M.D., Lexington

Medicare Review Committee

William H. Powers, M.D., Louisville, Chairman
T. M. Marshall, M.D., Louisville
William J. Sandman, M.D., Louisville
Bernard J. Schoo, M.D., Louisville
Robert S. Tillett, M.D., Louisville

Committee on Aging

Earl P. Oliver, M.D., Scottsville, Chairman
Thomas E. Averitt, M.D., Winchester
Joseph G. Braun, M.D., Newport
Ralph M. Denham, M.D., Louisville
J. Duffy Hancock, M.D., Louisville
Albert S. Irving, M.D., Louisville
R. O. Joplin, M.D., Louisville
Robert S. Leake, M.D., Covington
Alec Spencer, M.D., West Liberty

Council on Communications and Public Service

N. Lewis Bosworth, M.D., Lexington, Chairman
Carl Cooper, Jr., M.D., Bedford
R. E. Davis, M.D., Central City
Donald L. Graves, M.D., Frenchburg
Irving F. Kanner, M.D., Lexington
Ralph D. Lynn, M.D., Elkton
John Robbins, M.D., Louisville

Rural Health Committee

Donald L. Graves, M.D., Frenchburg, Chairman
John M. Baird, M.D., Danville
Thornton E. Bryan, Jr., M.D., Cadiz
William H. Cox, M.D., Paris
Joseph Hamburg, M.D., Lexington
Clifford F. Kerby, M.D., Berea
Carl Pigman, M.D., Whitesburg
James C. Salato, M.D., Columbia

Diabetes Committee

Irving F. Kanner, M.D., Lexington, Chairman
C. L. Allen, M.D., Langley
Robert G. Wheeler, M.D., Georgetown
William W. Winternitz, M.D., Lexington
Lloyd G. Yopp, M.D., Louisville

Committee on Disaster Medical Care

William T. Rumage, Jr., M.D., Louisville, Chairman
Richard L. Colley, M.D., Mayfield
George E. Estill, M.D., Maysville
Richard B. Floyd, III, M.D., Lexington
Don C. Haugh, M.D., Mayfield
Robert E. Reichert, M.D., Covington
Joseph D. Stokes, M.D., Greenville

School Health Committee

R. E. Davis, M.D., Central City, Chairman
William B. Haley, M.D., Paducah
Charles B. Johnson, M.D., Russell
John W. Miller, M.D., Louisville
O. B. Murphy, M.D., Lexington
C. B. VanArsdall, Jr., M.D., Harrodsburg
Livingston A. Wahle, M.D., Shelbyville
Henry Wilbur, D. D. S., Anchorage

Highway Safety Committee

John J. Robbins, M.D., Louisville, Chairman
Herald K. Bailey, M.D., Ashland
R. Arnold Griswold, M.D., Louisville
Arthur H. Keeney, M.D., Louisville
William K. Keller, M.D., Louisville
William T. Rumage, Jr., M.D., Louisville
Claude W. Trapp, Jr., M.D., Lexington

Public Health Committee

Ralph D. Lynn, M.D., Elkton, Chairman
John E. Cotthoff, M.D., Hopkinsville
Marcus A. Coyle, M.D., Springfield
Russell L. Hall, M.D., Prestonsburg
Arthur T. Hurst, M.D., Louisville
Holmes Goodlow Sargent, M.D., Paducah
M. A. Shepherd, M.D., Somerset
Joseph M. Withers, M.D., Cynthiana

Advisory Committee to Woman's Auxiliary

Jesse T. Funk, M.D., Bowling Green, Chairman
J. Andrew Bowen, M.D., Louisville
Coleman C. Johnston, M.D., Lexington

Senior Day Committee

Carl Cooper, Jr., M.D., Bedford, Chairman
Thomas R. Bryant, M.D., Lexington
Eugene H. Conner, M.D., Louisville
Barney E. Elliott, M.D., Morganfield
Hoyt D. Gardner, M.D., Louisville
Roy H. Moore, M.D., Louisville
Charles E. Rankin, M.D., Lexington

Committee on Medicine and Religion

Avrom M. Isaacs, M.D., Louisville
Harold Keen, M.D., Bowling Green
Joseph H. Saunders, M.D., Lexington
John R. Stevie, M.D., Covington
Lewis E. Wesley, M.D., Liberty

Council on Allied Professions and Related Groups

William K. Massie, M.D., Lexington, Chairman
Guy C. Cunningham, M.D., Ashland
Ellis A. Fuller, Jr., M.D., Louisville
Joseph Humpert, M.D., South Fort Mitchell
Gradie R. Rowntree, M.D., Louisville
Melvin J. Weber, M.D., Ludlow

Dental-Nurse-Pharmacy Committee

Melvin J. Weber, M.D., Ludlow, Chairman
Coy Edwin Ball, M.D., Glasgow
Winston L. Burke, M.D., Lexington
William C. Mitchell, M.D., Louisville
Henry S. Spalding, M.D., Bardstown

Physical Medicine and Rehabilitation Committee

William K. Massie, M.D., Lexington, Chairman
Harry D. Abell, Jr., M.D., Paducah
John S. Ashworth, M.D., Ashland
Kenton D. Leatherman, M.D., Louisville
Joe T. Pettey, M.D., Russell Springs
Otto H. Salsbery, M.D., Covington
Joseph E. Warren, M.D., Lexington

Maternal Mortality Study Committee

John H. Siehl, M.D., Covington, Chairman
James Becknell, M.D., Manchester
Peter P. Bosomworth, M.D., Lexington
Joe M. Bush, M.D., Mt. Sterling
William C. Durham, M.D., Louisville
Oliver Fearing, M.D., Ashland
Robert J. Griffin, M.D., Lexington
John Handley, M.D., Hodgenville
Douglas M. Haynes, M.D., Louisville
Lawrence T. Hiltz, M.D., Covington
Charles E. Hornaday, M.D., Owensboro
Robert L. Houston, Jr., M.D., Eminence
Clarence J. McGruder, M.D., Henderson
Joseph Miller, M.D., Benton
Robert F. Monroe, M.D., Louisville
Robert A. Orr, M.D., Mayfield
William H. Parker, M.D., Owensboro
John A. Petry, M.D., Fern Creek
Harold Priddle, M.D., Paducah
Barton Ramsey, M.D., Somerset
Jere Robertson, M.D., Hopkinsville
Keith P. Smith, M.D., Corbin
Edwin P. Solomon, M.D., Louisville
A. J. Whitehouse, M.D., Lexington
Harper Wright, M.D., Bowling Green
Roemer D. Pitman, M.D., Williamsburg

Perinatal Mortality and Morbidity Study Committee

Guy Cunningham, M.D., Ashland, Chairman
Jeffries L. Blackerby, M.D., Lexington
Keith M. Coverdale, M.D., Bowling Green
John H. Doyle, M.D., Louisville
William R. Gabbert, M.D., Owensboro
Lawrence U. Gilliam, M.D., Corbin
Robert McLeod, M.D., Somerset
Robert Rice, M.D., Richmond
William J. Temple, M.D., Covington
Fred Weller, M.D., Middlesboro
William C. Young, M.D., Hopkinsville

Tuberculosis Committee

Joseph Humpert, M.D., South Fort Mitchell, Chairman
J. Ray Bryant, M.D., Louisville
Shelby Hicks, M.D., New Castle
Richard Mardis, M.D., Louisville
Adam Miller, M.D., Lexington
Franklin B. Moosnick, M.D., Lexington
Lawrence A. Taugher, M.D., Louisville

Blood Bank Committee

Ellis Fuller, M.D., Louisville, Chairman
H. C. Burkhart, M.D., Harlan
John E. Cotthoff, M.D., Hopkinsville
James T. McClellan, M.D., Lexington
M. David Orrahood, M.D., Owensboro
E. G. Prewitt, M.D., Corbin
George Tanner, M.D., Fort Thomas

Industrial Medicine Committee

Gradie R. Rowntree, M.D., Louisville, Chairman
Charles Allen, M.D., Louisville
W. Vernon Lee, M.D., Covington
William G. Morgan, M.D., Owensboro
Walter L. O'Nan, M.D., Henderson

MISCELLANEOUS AND STANDING

Judicial Council

Henry B. Asman, M.D., Louisville
Clyde C. Sparks, M.D., Ashland
J. Duffy Hancock, M.D., Louisville
Hugh L. Houston, M.D., Murray
N. Lewis Bosworth, M.D., Lexington

Advisory Committee to the Editor

Blaine Lewis, Jr., M.D., Louisville, Chairman
Patrick J. Murphy, M.D., Lebanon Junction
Gerald B. Reams, M.D., Ashland
Willett H. Rush, M.D., Frankfort
Frederick Scott, M.D., Madisonville
Orson P. Smith, M.D., Louisville

Committee on Third Party Medicine

J. S. Harter, M.D., Louisville, Chairman
Walter L. Boswell, M.D., Lexington
Ballard W. Cassady, M.D., Pikeville
Robert B. Jasper, M.D., Somerset
Robert E. Norsworthy, M.D., Hartford

Committee to Study the Constitution and Bylaws

Robert S. Dyer, M.D., Louisville, Chairman
John S. Baughman, III, M.D., Harrodsburg
Matthew C. Darnell, Jr., M.D., Lexington
W. Bruce Hamilton, M.D., Shepherdsville
Douglas H. Jenkins, M.D., Richmond
James G. Sills, M.D., Hardinsburg

Interim Meeting Program Committee

Delmas M. Clardy, M.D., Hopkinsville, Chairman
W. Gerald Edds, M.D., Calhoun
William W. Hall, M.D., Owensboro
Robert E. Pennington, M.D., London

KSMA Technical Advisory Committee on Indigent Medical Care

Clyde C. Sparks, M.D., Ashland, Chairman
Owen Davis, M.D., Scottsville
George E. Estill, M.D., Maysville
Paul F. Maddox, M.D., Campton
Carroll H. Robie, Jr., M.D., Louisville
Harold Schupbach, M.D., Owensboro
Claude C. Waldrop, M.D., Williamstown

Insurance Review Board

William C. Mitchell, M.D., Louisville, Chancellor
Bernard J. Baute, M.D., Lebanon
Jack L. Chumley, M.D., Louisville
Harvey Chenault, M.D., Lexington
John Dickinson, M.D., Glasgow
Albert S. Irving, M.D., Louisville
Paul H. Klingenberg, M.D., South Fort Mitchell

KSMA Representative to Conference of Presidents and Other State Medical Association Officers

Delmas M. Clardy, M.D., Hopkinsville

KSMA Representative, Advisory Committee to U. of K. Chapter, Student AMA

Richard Segnitz, M.D., Lexington

KSMA Representative, Advisory Committee to U. of L. Chapter, Student AMA

Hoyt D. Gardner, M.D., Louisville

KSMA Representative on Practical Nurse Training

Glenn R. Powell, M.D., Paintsville

KSMA Representative on Advisory Committee, Maternal and Child Health, of the State Department of Health

McDowell Home Committee

Laman A. Gray, M.D., Louisville, Chairman
Robert C. Bateman, M.D., Danville
Rankin C. Blount, M.D., Lexington
Mr. Sterling Coke, Lexington
Norman Franke, Lexington
Mr. George Grider, Danville
E. M. Howard, M.D., Harlan
David W. Kinnaird, M.D., Louisville
Harold Priddle, M.D., Paducah
Richard H. Segnitz, M.D., Lexington
B. B. Baughman, M.D., Frankfort

Advisory Committee to Selective Service

J. Duffy Hancock, M.D., Louisville, Chairman
Glenn U. Dorroh, M.D., Lexington, Vice-Chairman
James Archer, M.D., Paintsville
Charles B. Billington, M.D., Paducah
O. B. Coomer, D. D. S., Louisville
Sydney G. Dyer, M.D., LaCenter
Sam A. Overstreet, M.D., Louisville
Marcus Randall, D. D. S., Louisville
L. S. Sherill, D.V.M.
Russell E. Teague, M.D., Frankfort
L. O. Toomey, M.D., Bowling Green
Celestia Uptring, R.N., Louisville

Memorials Commission

Carlisle Morse, M.D., Louisville, Chairman
Eugene H. Conner, M.D., Louisville
G. Y. Graves, M.D., Bowling Green
J. Duffy Hancock, M.D., Louisville
Francis Massie, M.D., Lexington

Certificates of Vaccination Needed for Foreign Travel

If you have patients who are planning foreign travel, you are urged to remind them that the most important document for foreign travel (next to the passport) is the "International Certificates of Vaccination".

World travelers who forget this fact run into delays in quarantine because they fail to present a valid international certificate of vaccination against smallpox.

In the U. S. the certificate is published as Public Health Service Form 731, "International Certificates of Vaccination", revised June 1961. It is given out with the passport application and also may be obtained from the local and State health departments or from offices of the USPHS. To be valid for international travel the certificate must be completed in every detail.

Lesions of the Pancreas

Continued from Page 943

marred, because some patients continue to drink and succumb from the effects of their chronic alcoholism, diabetes and malnutrition. However, in the patients who have ceased to drink, the results of the procedure have been excellent. When obstructive jaundice, from a stricture of the bile duct, is present, a bile shunt should be carried out by anastomosing the bile duct above the strictured area to the duodenum or a defunctionalized loop of jejunum.

Bibliography

1. Opie, E. L.: *The Relation of Cholelithiasis to Disease of the Pancreas and to Fat-Necrosis.* Bull. Johns Hopkins Hosp., 12:19, 1901.
2. Robinson, T. M., and Dunphy, J. E.: *Continuous Perfusion of Bile and Protease Activators Through the Pancreas. J.A.M.A.,* 183:530, 1963.
3. Menguy, R., Hallenbeck, G. A., Bollman, J. L., and Grindlay, J. H.: *Ductal and Vascular Factors in the Etiology of Experimentally Induced Acute Pancreatis.* Arch. Surg., 74:881, 1957.
4. Edmonson, H. A., Berne, C. J., Homann, R. D., Jr., and Wertman, M.: *Calcium Potassium, Magnesium and Amylase Disturbances in Acute Pancreatitis,* Am. J. Med., 12:34, 1952.
5. Albrink, M. J. and Klatskin, G.: Lactescence of Serum Following Episodes of *Acute Alcoholism and its Probable Relationship to Acute Pancreatitis.* Am. J. Med., 23:26, 1957.
6. Breitenecker, R.: *Fatal Gastrointestinal Hemorrhage Due to Chronic Relapsing Pancreatitis.* N. Eng. J. Med., 260:1167, 1959.
7. Henke, W. J., Vacca, J. B., Goidsenhoven, G. F., and Knight, W. A.: *Evaluation of Pancreatic Function Tests in Confirmed Pancreatic Disease,* Gastroenterology, 41:233, 1961.
8. Puestow, C. B., and Gillesby, W. J.: *Retrograde Surgical Drainage of Pancreas for Chronic Relapsing Pancreatitis.* Arch. Surg., 76:898, 1958.

THE ARTHRITICS WHO COULD NOT TAKE STEROIDS

The bane of the steroids, new and old, has been tha certain undesirable metabolic effects — including sal and water retention, edema, overstimulation of the appetite, excessive weight gain, mood swings — seemed to be firmly linked to the primary anti inflammatory action. For arthritics already overweight or with cardiovascular disease complicated by edema or those who were tense and anxious, steroid treat ment could aggravate their problems. But with the advent of ARISTOCORT® Triamcinolone, many of these arthritics became "steroid-treatable." The rea son: Not only did *this* steroid provide gratifying relief of inflammation and pain, but it did so *without* the penalty of overstimulation of the appetite, excessive weight gain, salt and water retention, edema, and undesirable euphoria. Six years of widespread use has confirmed these benefits for other arthritics as well as those formerly untreatable.



Side Effects: Since it may, under some circumstances, produce many of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.
Contraindications: While the only absolute contraindications are tuberculosis, herpes simplex and chicken pox, there are some relative contraindications (peptic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.
A single daily dose may provide effective control, is convenient for the patient, and can be employed in both initial and maintenance therapy.

MAXIMUM STEROID BENEFIT – MINIMUM STEROID PENALTY

Aristocort®
Triamcinolone

scored tablets of 1 mg., 2 mg., 4 mg., 8 mg. or 16 mg.

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

270-4



Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE MARK ®

NEW MEN'S SHOP



. . . in our NEW SOUTHERN OPTICAL BUILDING, 640 S. 4th St., between Broadway and Chestnut . . . where a man is king. In its masculine surroundings, you'll experience the same comfort while being fitted for glasses as you do when being fitted for clothes.

GUILD OPTICIANS Southern Optical

SOUTHERN OPTICAL BLDG 640 S 4th
(Midway between Broadway & Chestnut
MEDICAL ARTS BLDG., Eastern Parkway
ST MATTHEWS, Wallace Center
MEDICAL TOWERS BLDG, Floyd & Gray
CONTACT LENSES, 640 S 4th

1964 CONSTITUTION AND BYLAWS
OF THE
KENTUCKY MEDICAL ASSOCIATION

Revised September 30, 1964

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition and Meetings of the Association
Article V. Officers
Article VI. House of Delegates
Article VII. Districts, Sections and District Societies
Article VIII. Board of Trustees
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the bylaws.

Section 2. The duties and terms of office of all officers of the Association shall be as prescribed in the bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select,

including but not limited to an equal per capita assessment by class of membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Meetings of the Association
Chapter III. The House of Delegates
Chapter IV. Election of Officers
Chapter V. Duties of Officers
Chapter VI. Board of Trustees
Chapter VII. Discipline—The Judicial Council
Chapter VIII. Standing Committees and Councils
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI. Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

CHAPTER 1. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into seven classes, to-wit: Active, Emeritus, Associate, Inactive, Student, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall have the right to vote but shall not pay dues, hold office or be entitled to the benefits of Chapter VI, Section 9 of these Bylaws. They shall receive the Journal and other publications of the Association.

(c) Associate Members. The associate membership of the Association shall consist of the associate members of the various component county medical societies. To be eligible for associate membership in any component county society, the applicant must be ineligible for active membership and qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

Associate members shall not have the right to vote nor to hold office, but shall receive the Journal and other publications of the Association.

(d) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive the Journal and other publications of the Association.

(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of

their choice. Student members shall receive the Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(g) Special Members. Component societies may invite dentists, pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society. Provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. Except as provided in Chapter VI, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association, shall be entitled to any of the rights or benefits of membership in this Association.

Section 5. Every active member shall occupy a provisional status for two years immediately following his admission to membership in the Association, during which period he must successfully complete an orientation course to be presented at stated intervals by the Board of Trustees or one of its committees. The form and content of this course shall be prescribed by the Board and unless excused by the Board for good cause shown, failure to attend and successfully complete the course within the two-year period shall automatically revoke the delinquent's membership and terminate all of his rights and privileges as a member, and he shall thereafter, for a period of one year, be ineligible for membership in any component county society.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or one of the vice presidents. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of delegates representing fifty or more component societies. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active members of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 6. Forty per cent of the qualified delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 7. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 8. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 9. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 10. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical

and public health legislation, and to diffuse information in relation thereto.

Section 11. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 12. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 13. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 14. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 15. The state shall be divided into the following districts:

No. 1.—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 16. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 17. Except as provided in Chapter VI, Section 4, it shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 18. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker of the House of Delegates, the Vice-Speaker of the House, the Secretary and the Treasurer shall be elected for terms of three years. The Trustees shall be elected for terms of three years and shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice President, Speaker or Vice Speaker of the House of Delegates, or Trustees, who has not been an active member of the Association for at least five years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the Interim Meeting, or at some other appropriate place designated by the Board of Trustees at least four months before the Annual Meeting. The Committee, in addition to such other meetings as it may choose to hold, shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Before noon of the following day, the Committee shall post a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nominations for each office to be filled, and shall formally present said nominations to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussions or comment.

Section 3. The election of officers shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect. Provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of the Association shall be ineligible for any office for two years.

Section 6. The Delegates representing the counties in each District shall form the Nominating Committee for the purpose of nominating a Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting, for the purpose of discussing the nomination for the Trustee to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office

and so far as practicable, shall visit by appointment, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice Presidents shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President from the district from which the President was elected shall succeed to the office of the President.

Section 4. The President-Elect and the Vice Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties, in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses of the President.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Section 8. The Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be countersigned by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President or the Chairman of the Board of Trustees is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Board of Trustees. The Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the three Vice Presidents, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the President-Elect, the Secretary, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the existing component societies and their members. He shall likewise hold at least one district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Treasurer upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press. Such communications shall be signed by the President of the Association and the Chairman of the Board.

Section 5. The Journal of the Kentucky Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the President may call a meeting of the delegates of record from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the Trustee's disability is removed or until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Board, which may elect an acting Trustee from them.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners in the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky Medical Association under supervision of the Board and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or as Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary, shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine should be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Health for this purpose.

At the request of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all such cases of initiation. intervention, or supersession, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In the case of ap-

peals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation, the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable the Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complaint and the respondent shall each be entitled to the counsel of any physician of his choice, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recomendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

CHAPTER VIII. STANDING COMMITTEES AND COUNCILS

Section 1. The Board of Trustees shall, upon nomination of its Executive Committee, appoint and designate the chairmen of four standing committees composed of not less than five nor more than seven members, as follows:

(a) A Committee to Study the Constitution and Bylaws.
(b) A Committee on Third-Party Medicine.
(c) A Committee on Arrangements for the Interim Meeting.
(d) An Advisory Committee to the Editor of the Journal.

Section 2. The Board of Trustees shall, in the same manner, (except as hereinafter provided) appoint and designate the chairmen of six Councils, composed of not less than five nor more than seven members, as follows:

(a) A Council on Scientific Assembly.
(b) A Council on Medical Education and Hospitals.
(c) A Council on Legislative Activities.
(d) A Council on Medical Services.
(e) A Council on Communications and Public Service.
(f) A Council on Allied Professions and Related Groups.

Section 3. The Executive Committee shall serve as the nominating committee for all Standing Committee and Council appointments, but the Trustees may make additional nominations from the floor. When the Executive Committee sits as such nominating committee, the President shall serve as Chairman.

Section 4. Except as otherwise provided herein, members of Standing Committees and Councils shall be appointed for terms of not less than one year and of not more than three years, and until their successors are appointed. Each committee and council (other than the Council on Scientific Assembly) shall meet and organize as soon after its appointment as possible, and shall meet again near the close of the associational year, for the purpose of formulating its annual report. It may meet at such other times as may be necessary or desirable. The Headquarters Office shall be the headquarters for all Committees and Councils, unless otherwise specifically ordered by the Board of Trustees or its Executive Committee.

Five-member Committees and Councils shall have a quorum of three, and seven-member Committees and Councils shall have a quorum of four members present before any business other than the fixing of the time and place of the next meeting, may be transacted.

All committees, other than standing committees, shall be assigned to a council and shall report their activities and recommendations *only* to the council to which assigned. These reports will be reviewed by the various councils and no such reports or recommendations will be considered by the Board of Trustees unless and until reviewed by the proper council.

Each Standing Committee and Council shall report annually, at least six weeks prior to the Annual Meeting, to the House of Delegates via the Board of Trustees respecting its activities during the year last past. These reports shall be transmitted, without alteration or amendment, to the House of Delegates by the Board of Trustees at the Annual Meeting, with such comments or recommendations as the Board cares to make. Committees and Councils may submit supplemental reports if such reports are in the hands of the Secretary at least 48 hours in advance of the first meeting of the Regular Session of the House of Delegates.

Section 5. The President, Secretary, and Executive Secretary shall be ex officio members of all Committees and Councils, without power to vote except as otherwise specified herein.

Section 6. The Board of Trustees shall have power to establish such other committees as may, from time to time, appear to it to be advisable, and to prescribe

their composition, the method of their appointment, and their duties. Such committees shall serve at the pleasure of the Board.

In addition, the Board of Trustees shall have power to appoint a representative from this Association to the Conference of Presidents and such other organizations as it shall determine.

Section 7. The Committee to Study the Constitution and Bylaws shall make a continuing study of the Constitution and Bylaws and shall annually recommend such revisions of either or both of these documents as changing times and conditions indicate.

Section 8. The Committee on Third Party Medicine shall make a continuing study of Third Party Medicine, and shall maintain liaison with all medical care plans which employ physicians on a salaried basis in this state. It shall mediate disputes between members and such plans, and shall continually strive to persuade such plans to shape their relations with their employed physicians and with the public, in conformity to the views of this Association.

Section 9. The Committee on Arrangements for the Interim Meeting shall have the responsibility of preparing the program for the Interim Meeting, and presenting it to the Board of Trustees or its Executive Committee for approval. Upon approval of the program thus presented, the Committee shall have the further responsibility of approving all arrangements for the Conference.

Section 10. The Advisory Committee to the Editor of the Journal shall provide support to the Editor and be available to him for consultation with respect to any matter concerning the Journal, on which he desires the Committee's advice and assistance. All papers of doubtful suitability for publication shall be referred by the Editor to the Advisory Committee, and its approval shall be required prior to the publication of any matter which is recognized to be of a controversial nature.

Section 11. The Council on Scientific Assembly shall consist of seven (7) members. The President, the President-Elect, and the chairmen of the Committees on Scientific and Technical Exhibits shall, by virtue of their respective offices, be voting members of the Council, with the President serving as Chairman and the President-Elect as Vice-Chairman. The remaining three members shall serve for terms of three (3) years each, with the term of one member expiring each year. The Council shall supervise and direct the planning, development and presentation of the scientific programs of the Annual Meeting each year. In addition, it shall be responsible for scientific and technical exhibits and all activities incident to the Annual Meeting, including golf and other forms of recreation and entertainment. These will include the duties heretofore imposed upon the Awards Committee to nominate the recipients of the Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award.

Thirty (30) days previous to each Annual Meeting, the Council shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented, which program shall be adhered to as nearly as practicable. No county society, as such, shall serve as host society to the Annual Meeting.

Section 12. The Council on Medical Education and Hospitals shall direct and supervise the activities of the Association in the field of medical education, and shall maintain active liaison with the Kentucky Hospital Association. It shall seek to elevate the standards of postgraduate medical education in Kentucky, establishing and maintaining liaison with Kentucky's two medical schools and the Committee for the American Medical Association Education Research Foundation, and concerning itself with problems relating to medical and hospital care, general practice, and such other matters in this general field as may be referred to it by the Board.

Section 13. The Council on Legislative Activities shall direct and supervise the work of the Association as it pertains to state and national legislation, and shall formulate and submit a legislative program to the Board of Trustees for its consideration. The Council shall seek the enactment of the Association's legislative program into law, and shall resist the enactment of bills which the Board finds to be not in the best interests of the public or the profession. It shall maintain liaison with officials of state and national governments and shall work closely with the various county societies in carrying out the legislative program at both state and national levels.

Section 14. The Council on Medical Services shall supervise and direct the activities of the Association in the field of socio-economic development. It shall be charged with the promotion of voluntary health insurance programs in general and shall maintain active liaison with Kentucky Physicians Mutual, Inc., and Blue Cross plans. It shall advise on medical service contracts with the state and federal governments and shall serve as a clearing house on all fee schedules and other questions affecting the economics of medicine. It shall concern itself with the problem of providing adequate medical care for the aged, and shall maintain careful scrutiny of all state or national programs which purport to deal with this problem.

Section 15. The Council on Communications and Public Service shall supervise and direct all associational activity in the fields of public relations and service, including, but not limited to, rural health, schools, public health, emergency medical services and diabetes.

Section 16. The Council on Allied Professions and Related Groups shall concern itself with the development and promotion of improved health standards and shall establish and maintain liaison with the dental, nursing and pharmacy professions in this state. It shall supervise and direct the Association's activities in the fields of infant and maternal mortality, physical medicine and rehabilitation, industrial medicine, tuberculosis, blood banks and other related subjects, and shall interest itself in the work of voluntary health associations.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $75, except Active Members who devote all of their time to teaching or research and have no private practice, $50.00; (2) Emeritus Members, no dues; (3) Associate Members, $8; (4) Inactive Members, $8; (5) Student Members, $1; (6) Honorary Members, no dues; (7) Special Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each component society shall forward its assessment together with its roster of all officers and members, list of delegates and list of non-affiliated physicians of the county to the Secretary of this Association as of the first day of January in each year.

Section 2. Any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 4 of this Chapter, all county medical societies in this state which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one statewide society of worthy Negro physicians who are not members of any component society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 5. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Section 6. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association, and shall be classified in accordance with Chapter I, Section 2 of these Bylaws. Provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 9 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 9. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 10. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership. Provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session. Provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 members in good standing, plus one delegate for one or more members in excess of multiples of 25. Provided, however that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send

a list of such delegates to the Secretary of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

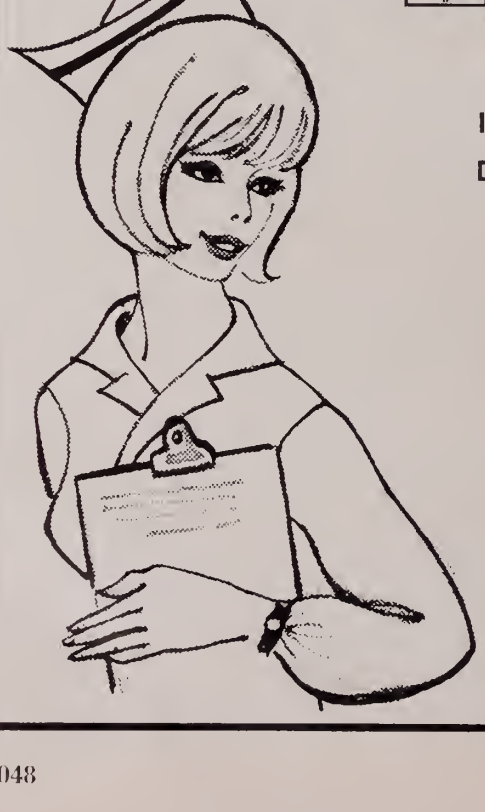
Section 13. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary of the Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each component society shall report to the Journal of the Kentucky Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER XIII. AMENDMENTS

These Bylaws may be amended at any session of the House of Delegates by a two-thirds vote of all the delegates present at that session, after the amendment has laid on the table for one day.

MURFREESBORO - VACANCIES: STAFF PHYSICIANS for 1275 bed neuropsychiatric hospital, including 350 general medical and geriatric. Modern facilities for diagnosis and treatment of mental illness. Salary $11,150 to $18,405 depending on qualifications; fringe benefits; cost of moving to Murfreesboro will be paid by Veterans Administration; visit here for evaluation can be arranged at our expense. Excellent educational opportunities for students in this area. Contact Director, Veterans Administration Hospital, Murfreesboro, Tenn.



MT. HOLLY NURSING HOME

A Nursing Home with Hospital Standards

In Nursing Homes, Professional Staff Makes The Difference. Competent Care Is The Big Thing.

Mt. Holly provides the finest care for your Geriatrics-Orthopedics and Medical Patients. Both young and old will be served on either a short-term or long-term basis.

- *Listed With the American Hospital Assn.*
- *Approved for Blue Cross-Blue Shield*

446 MT. HOLLY AVE. OFF BROWNSBORO ROAD
897-1646

THE JOURNAL

of the

KENTUCKY MEDICAL ASSOCIATION

Index to Volume 62—1964

January	Pages 1 to 92	July	Pages 495 to 566
February	Pages 93 to 178	August	Pages 567 to 642
March	Pages 179 to 258	September	Pages 643 to 738
April	Pages 259 to 340	October	Pages 739 to 826
May	Pages 341 to 416	November	Pages 827 to 914
June	Pages 417 to 494	December	Pages 915 to 1058

Edited by Sam A. Overstreet, M.D.

Under the Supervision of the Board of Trustees

SCIENTIFIC ARTICLES

A

Adenomyosis—A Tissue Committee Analysis, 120
Allergic Emergency, The—Aftermath of Modern Therapeutics, 433, 523
Allergy in Otolaryngology, 517
Anesthesia, Perspective in, 437
Anesthetics, A Review and Evaluation of 800 Administered For Cesarean Section Delivery, 765
Appendicitis in Pregnancy, 944

B

Bilateral Symmetric Recession of the Horizontal Rectus Muscles, 581
Bone Marrow Failure and Myelofibrosis, 208

C

Cancer of the Ovary—The Need for Early Diagnosis 372
Cesarean Section Delivery, A Review and Evaluation of 800 Consecutive Anesthetics Administered for, 765
Chemical, Bacteriological and Radiological Warfare, 24
Chondromalacia of the Patella, 527
Civil Defense Disaster Plans for Kentucky, 31
Civil Defense Emergency Hospital in Kentucky, The, 36
Clinical Neurological Surgery, Current Advances in, 200
Colonic Polyps: A Surgical Pathology Dilemma, 444
Control of Fertility, 195
Cutaneous and Mucous Membranous Clues to Some Systemic Diseases, 359

D

Dermatology, What's New In, 284
Diabetes Mellitus, Epidemiologic Association of Environmental Factors in, 511
Disaster Medical Care, AMA Activity In, 20
Dyspareunia Due to Conditions of the Introitus, 122

E

Education and Training of Physicians and Psychiatrists for Community Psychiatry, 286
Emergency Health Services in Kentucky, 34
Epidemiologic Associations of Environmental Factors with Diabetes Mellitus, 511
Evacuation and/or Shelters—When and Where in Kentucky, 32

F

Four Lesser Veneral Diseases, 281

G

Glaucoma Screening in Kentucky, 289

H

Head and Neck Lesions, Out-Patient Treatment of, 587
Heart Disease, Some Present and Future Problems in the Treatment of, 753
Heart Failure and Adams-Stokes Attacks from Complete Heart Block—Surgical Treatment with Cardiac Pacemaker, 365
"Hematologic" Tumors of the Head and Neck, 369

L

Liver Biopsy: A Ten-Year Survey at Louisville General Hospital, 857
Lung Cancer, Environmental Factors in, 206

M

Mass Glaucoma Screening in Kentucky, 289
Mechanical Respirators, The Importance of Added Humidity with, 211
Medicine, Government, and Disaster Planning, 22

O

Obstetrics, Office, 125
Occiput Posterior, Management of the, 860
Ovulation, Stimulation of, 441

P

Paroxysmal Ventricular Fibrillation, 596
Pheochromocytoma: Recent Experiences with Two Cases, 853
Placentascan as a Diagnostic Aid, 761
Preleukemia: An Unusual Case of Nine Years' Duration, 862
Pulmonary Abscess, Early Treatment of, 133

R

Red Cross and Disaster Planning, The, 40
Review and Evaluation of 800 Consecutive Anesthetics Administered for Cesarean Section Delivery, 765
Roentgenography of the Breast, 128
Role and Contributions of a State Mental Health Department to Community Mental Health, 868
Role and Contribution of the Psychiatrist in Private Practice, The, 947
Role of a Non-Psychiatric Physician in a Mental Health Program, The, 768

S

Selective Gastric Vagotomy, 865
Septic Shock, Pathogenesis and Treatment of, 590
Snakebite Accidents in Kentucky, 275
Some Present and Future Problems in the Treatment of Heart Disease, 753
Sudden, Unexpected Death in Infancy, 949
Surgical Management of Inflammatory Lesions of the Pancreas, 937
Surgical Treatment of Heart Failure and Adams-Stokes Attacks from Complete Heart Block with a Cardiac Pacemaker, 365

Thyroid Status, Definition of, and Detection of Factitious Test Results by Combined RAI Uptake and PBI Determination, 115

U

Urinary Tract Infection—Past, Present and Future, 661

V

Venereal Diseases, Four Lesser, 281

Y

You, Your Hospital and Disaster Planning in Kentucky, 38

SCIENTIFIC ARTICLES LISTED BY AUTHORS

A

Anderson, Jack R., 523

B

Baker, Harold W., 122
Baker, Thomas H., 944
Barker, Denzil G., 125
Brewer, Ben R., 38
Bryan, James E., 853
Bryant, Lester R., 211

C

Callahan, Edward, 949
Clay, Jennifer, 949
Costigan, Daniel G., 527
Coy, Fred E., 527
Crossen, Philip S., 441

D

Davis, David M., 661
Donovan, P., 275

E

Eichner, Eduard, 211
Eiseman, Ben, 365

F

Fadell, Edward J., 444
Farabee, Dale H., 868
Ferrazzano, Gabriel P., 22

G

Gardiner, Sprague, 765
Gray, William R., 596
Griffin, Robert J., 860
Grimes, Allen E., 372
Goldner, Martin G., 511

H

Hackett, Louis J., Jr., 32
Haley, William B., 38
Harrison, Tinsley R., 753
Holland, Bernard C., 286
House, Darrell, 40
Hull, David A., 865
Hyde, Gordon L., 865

J

Jackson, Benjamin B., 853
Jacoby, Jay, 437
Johnson, Hollis, 947

K

Klimt, Christian R., 206, 511

L

Lansing, Allan M., 590
Lareau, Daniel G., 115
Lichter, Max L., 20
Lieber, Arthur, 128
Lucas, Marvin A., 444

M

Mayo, W. Porter, 133
McDaniel, William E., 281
Meacham, William F., 200
Menguy, Rene, 937
Moore, Andrew M., 587
Mottram, Evelyn, 125

O

Olash, F. Albert, 853
Orrahood, M. David, 120

P

Parrish, Henry M., 275
Perera, Charles A., 581
Perry, Harold O., 359
Porter, Robert A., 286
Price, David P., 857

R

Raccuglia, Giovanni, 369
Redd, Harold, 372
Reed, Leon J., 31
Reeves, J. T., 365
Reider, Frank, 36
Riley, James M., 527
Roesch, Ryland, 765

S

Schupbach, Harold J., 768
Shaffer, Joseph H., 433, 523
Shively, John A., 208
Spencer, Frank C., 365
Stambaugh, James L., 289
Stoelting, V. K., 765
Stokes, Forrest, 36
Stokes, Joseph, 24
Stowens, Daniel, 949
Sutherland, J. Patrick, 761

T

Teague, Russell E., 34

V

Vickers, F. Norman, 857

W

Ward, Will W., 862

CASE DISCUSSIONS

C

Carcinoma of the Uterine Cervix, The Role of Surgery in, 135

D

Depression Masquerading as Apathy, 292

E

Eclampsia, 871
Eclampsia with Postpartum Psychosis, 376
Evaluation of the Brain Injured Child, 530
Extensive Carcinoma of the Duodenum Treated by Pancreatico-Duodenectomy and Right Hemicolectomy, 599

L

Lupus-Like Syndrome Following Propylthiouracil Administration, A, 47

P

Peptic Esophagitis, 213
Pregnancy Complicated by Congenital Spherocytic Homolytic Anemia and Cystic Teratoma of Ovary, 450

T

Tetanus, 771

EDITORIALS

A

As Others See Us, 673

B

Brighter Outlook for Mental Health, A, 219

C

Charity Begins at Home, 383
Credit to Whom it is Due, 454

D

Dangerous Drugs, 778
Diabetes Week, 879

E

Emergency Medical Services, 19
Everybody's Doin' It Now, 877

F

Flanders Fields, In (Poem), 957
For a Better Kentucky, 605

G

Gastric Ulcer, 535
Gobble-De-Gook!, 51
Governor's Letter of Thanks for Disaster Care, 19

I

It Ranks with The Best, 672
It's That Time Again, 778

K

Kentucky Program on Medical Aspects of Driver Limitation, 382

M

Medicine's New Dimension, 50

P

Party Platforms, The, 777
Practitioner and the Fulltime Faculty Member, The, 219
Problem of Communication, A, 455

R

Records Show, The, 606
Remember the Southern, 673
Research Espionage, 51

S

Senior Day, 141

T

Thanks, 956
Thymus—Master Gland of Immunity?, 295
To Save a Life, 140



"Gesundheit!"

...is just for the sneeze

but for symptomatic relief of the common cold...

'EMPRAZIL'®

TABLETS

Each layered tablet contains:

'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

To relieve the aches, pains, fever and respiratory congestion of the common cold, flu or grippe with one product ...specify 'Emprazil'.

Caution: While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed.

Supplied: Bottles of 100 and 1000.

Also available with codeine—on prescription only—as **'EMPRAZIL-C'®** tablets

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

EDITORIALS LISTED BY AUTHORS

A

Asman, Henry B., 672

B

Breathitt, Edward T., 19

C

Chatham, Donald, 141
Coe, Walter S., 219, 606, 777, 956

F

Foltz, Louis M., 778

G

Gaines, Frank M., 219

K

Keeney, Arthur H., 382

L

Lansing, Allan M., 295

M

Massie, Francis M., 51
Moore, Andrew M., 455

O

Overstreet, Evan A., 535
Overstreet, Sam A., 50, 140, 383, 454, 535, 605, 673, 778, 877

R

Rumage, William T., 19

SPECIAL ARTICLES

A

Aims and Purposes of Medical Assistants, The, 874

C

Clinic for the Diagnosis and Treatment of Temporo-Mandibular Joint Disturbances, A., 218

D

Diabetes—An Old Enemy, 876
Disaster Committee Reports from Kentucky Counties, 44
Doctor Pope and His Building, 602

E

Emergency Medical Identification for Special Problems, 46

F

Fifty Years in the Practice of Medicine in Georgetown, 954
Flying Physicians to Assist in Emergency, 45

I

International Community Medicine Clerkship 1963-64—Iran, 379

K

Kentucky's Medical Care Program Passes Third Successful Birthday, 138
KSMA's Statement on King Anderson Bill as Presented Before the House Ways and Means Committee, 53

M

Medical Care Program for the Dependents of Uniformed Services Act, Answers to your Questions on The, 533
Medical Education for National Defense, 42

N

Nursing Home Administration Enhanced by Michigan State University, 294

O

On Succeeding in Medicine, 670

P

Physicians and Hospitals—Partners on the Health Team, 773
Pros and Cons of the Kerr-Mills Program in Kentucky, 452

R

Responsibility, 54

OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

You can obtain more detailed information by writing us direct.

WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member Americon Hospitol Assaciatian, Member Illinais Hospital Associotion. Licensed by the Department of Public Health, State of Illinais.

SPECIAL ARTICLES LISTED BY AUTHOR

C

Calvert, Carrie C., 294

D

Dachi, Stephen F., 218

E

English, Harlan, 670

F

Fisher, Bettye J., 874

G

Geist, Richard E., 379

H

Hendon, James Robert, 876

J

Johnson, Harry V., 954

K

Kinsman, Mrs. J. Murray, 54

R

Rouse, Milford O., 773

S

Simpson, Gaithel L., 53, 138, 452

W

Warren County Medical Society, 452

ORGANIZATION SECTION STORIES

A

AMA Committees, Five Ky. M.D.s appointed to, 386
AMA's 18th Clinical Convention Begins November 28 in Miami, 787
AMA Disaster Care Meeting Held in Louisville, 704
AMA Field Representative for Ky. is state native, 1018
AMA House of Delegates takes Stand on Tobacco and Human Rights, 618
AMA Mental Health Congress, Kentuckians to Participate, 885
AMA Miami Beach Meeting, KMA Members Planning to Attend, 881
AMA President Welch Dies During Wyoming Meeting, 790
AMA Scientific Program, Two Ky. M.D.s to Take Part, 460
AMA Sets Education Program on Available Health Care, 794
American College of Physicians Honor Eight Kentuckians, 152
Annis, Edward, M.D., Addresses Ky. General Assembly, 146
Annual Meeting, 1964, 299
Annual Meeting Phone is 584-2201 for Emergency Calls, 613
Annual Meeting, Preliminary Program 1964, 384
Annual Meeting Section (Program in Detail), 678
Annual Meeting, Top Speakers a Feature of, 460
Annual Meeting, Trans-Atlantic CPC to Highlight, 384
Automotive Medical Association to Meet in Louisville, 705
Archer, George P., M.D., Other Presidents Honored at AMA Session, 613

B

Baker, Everett H., M.D., Chosen by Delegates as KMA President-Elect, 880
Battered Child Law to Protect Children from Physical Abuse, 550
Big Springs Club Will Host 1964 KSMA Golf Tournament, 616
Blue Shield, Blue Cross Set Records in '63, 548
Blue Shield Performance Test Started May 18, 549
Blue Shield Special Section, 743
Board Asks County Societies to Hear Delegates Speak, 147
Board of Health Elects Dr. Higdon President, 145
Brown, Buster F., M.D., Installed as Public Health Head, 386

C

Chamber of Commerce, KSMA Members Urged to Support, 147
Chamber of Commerce (Louisville) Backs Plan to Form Area Hospital Council, 390
College of Surgeons Meeting Program Plans Released, 302
Community Health Week Observance Planned for October 18-24, 790
Congressman, How to Reach Your, 150
Congress on Mental Health Set May 14 in Louisville, 59
Congress on Mental Health Scheduled May 14, 300
Congress on Mental Heath Program, 301

D

Denham, Mitchel B., M.D. Elected Head of Ky. House Majority, 145
Denham, Mitchel B., M.D. Honored by KAGP, 464
Diabetes, Athletic Injury Panels Featured at Annual Meeting, 608
Diabetes Detection Drive, Record Participation Expected in, 787
Digest of Actions of AMA House at Portland Meeting, 60

F

Fifth District to Meet Jointly with Fourth and Seventh, 1016
First KHA Community Service Award Given to KSMA Exec. Secretary, 391
Five Kentucky M.D.s Appointed to AMA Committees, 386

G

Good Samaritan Proposal for Kentucky—Is it Necessary?, 540
Grogan, Bobbie R., Resigns Effective July 1, 542

H

Health-O-Drama to be Feature of 1964 Kentucky State Fair, 704
Health-O-Drama At Fair Features Protection, 788
Heart Disease Symposium Program Releases, 226
Hester, Lawrence L., M.D., Featured Speaker at Ky. Ob-Gyn Meeting, 305
Higdon, O. L., M.D., Elected Head of Ky. State Board of Health, 145
Hisle, W. Leon, to Head Hospital Association in 1965, 385
Horine, Emmet Field, M.D., In Memorian, 216-217
Hospital Surveys Fees to be Charged for, 148
"Hypertension" is Topic of January 23 Seminar, 59

I

Immunization Week, Ky. M.D.s Urged to Participate, 298
Industrial Medical Association Releases Meeting Program, 227
Interim Meeting, Dr. Nyaradi will Address, 58
Interim Meeting, Problems to be Analyzed by Top Speakers at, 144
Interim Meeting Plans Complete; Good Attendance Anticipated, 298
Interim Meeting Program, 223
Interim Meeting 1964, Sets Attendance Record, 462
Interim Meeting, 1965, Set for Owensboro March 18, 1016
Interim Meeting, Top Authorities to Discuss Medicare at, 222
Interim Meeting, Unusual Entertainment Planned for, 224

J

Jefferson County Disaster Care to get Plane Crash Test, 538
Johnson, Hollis, M.D., New President of Ky. Surgical Society, 469

K

KAGP Elects Dr. Witten President, Honors Dr. Denham, 464
KAGP Has Two-Day Seminar at Cumberland Falls, 705
KAGP Plans Annual Meeting in Louisville May 6-8, 234
KAGP Plans Outstanding Program for May 6-8, 304
Keller, William K., to Head U. of L. Psychiatry Department, 542
KEMPAC Dinner, Senators Bayh and Carlson Speak at, 885
KEMPAC Second Seminar Set as Annual Meeting Event, 609
Kentuckians to Participate in AMA Mental Health Congress, 885
Kentucky Well Represented in AMA House of Delegates, 59
Kentucky Well Represented at AMA Annual Meeting, 614
KMA 1964 Golf Tournament Won by Dr. Scalzitti, 885
KMA Members Planning to Attend AMA's Miami Beach Meeting, 881
KMA Membership Records Show All-Time High, 895
KMA Name Change Approved by House of Delegates, 894
KMA Woman's Auxiliary, Mrs. Salisbury Chosen President-Elect, 881
KSMA-AMA Leaders to Speak at KHA Meeting, 230
KSMA 1964 Annual Meeting Site is Modern, Convenient, Large, 299
KSMA Field Service Director Resigns Effective July 1, 542
KSMA Members Now More Active in AMA Posts, 59
KSMA Trustee District Meetings Scheduled, 299
KSMA Trustee Districts Hold May Meetings, 462
Ky. College of Surgeons Elects Dr. Robertson, 469
Ky. College of Surgeons Meeting Program, 302
Ky. Dental Association, Dr. Schuler President-Elect, 386
Ky. General Assembly Hears Talk by Dr. Annis on Kerr-Mills, 146
Ky. Hospital Association to Hear Top KSMA-AMA Speakers, 230
Ky. Hospital Association Gives First Community Service Award to KMA Executive Secretary, 391
Ky. Medical Assistants Install New Officers, 474
Ky. Medical Assistants Attend National Meetings, 1018
Ky. Pharmacists Elect Officers at July French Lick Meeting, 704
Ky. Ob-Gyn Society to Hear Dr. Hester, 305
Ky. Public Health Association—Dr. Brown Installed President, 386
Ky. Surgical Society Elects Dr. Johnston New President, 469
Ky. Surgical Society Program to Feature Dr. Warren, 308

L

Large Kentucky Delegation Registers at AMA Annual Meeting, 622
Letter to Young Physician Offers Ageless Advice, 550
Lexington Clinic Conference Offers Varied Program, 230
Lexington Clinic Conference Scheduled for April 1, 148
Ling, J. T., M.D., Named New Chairman of Radiology at U. of L., 69
Long, Robert C., M.D., Re-Elected to AMA Board of Trustees Post 614

Mc

McDowell House and Shop, Rare Books and Tile Accepted for, 226
McPheeters, Harold L., M.D., Resigns Post as Mental Health Head, 704

M

Membership Award Given KEMPAC in Portland, 58
Members Urged to Support State and Local C. of C., 147
Mental Health Congress Registration Totals 153, 463
Mental Health Congress Slated for May 14 in Louisville, 227
Mrs. Salisbury Chosen President-Elect of KMA Woman's Auxiliary, 881
Murray, Marvin A., M.D., Receives Award as Outstanding Educator, 390

N

Northern Ky. M.D.s Join in Annual Holy Retreat, 390
Norton Seminar December 17 Features Top Medical Lecturers, 788
Norton Seminary Set December 17, 1017

P

Parks, Harold F., Ph.D., New Chairman of U. of K. Anatomy Department, 705
Pennington, Robert E., M.D., and Chatham, Donald, M.D. to lead Board of Trustees, 880
Perry County Starts "Pay-All" Blue Shield Plan, 538
President's Luncheon Speaker Prescribes Dose of Laughter, 882

R

Rash, O. W., M.D., Marks 67 Years of Medical Practice, 388
Robertson, Robert W., M.D., New President of Ky. College of Surgeons, 469
Rural Health Conference Theme is "Health Careers", 787
Rural Ky. Scholarship Fund Grants New Loans to Eight, 464
Registered Nurses Elect Mrs. Turner, 1017
Rust, Richard J., M.D. Elected President of Ky. Physicians' Mutual Board, 1016

S

Scalzitti, C. J., M.D., Wins KMA 1964 Golf Tournament, 885
Schuler, Thomas H., D.D.S., President-Elect of Ky. Dental Association, 386
Scott, Douglas E., M.D., to Head SE Section of American Urologists, 460
Scroggin, Fred, M.D., Honored by Wildlife Federation, 304
Senators and Representatives Listed for 1964 Session, 64
Senior Day Programs Planned at U.K. and U. of L., 150
SMA 58th Annual Meeting Set November 16-19 in Memphis, 790

T

Texas Humorist to be Speaker at President's Luncheon, 609
Thoracic Society Plans April 23 Meeting, 230
Trans-Atlantic CPC To Highlight KSMA Annual Meeting, 384

U

U. of K., First Commencement, 456
U. of L. Alumni Reunion Set for AMA Annual Meeting, 308
U. of L. Announces Staff Appointments and Changes, 152
U. of L. Gets $45,000 for Aid in Curriculum Development, 548
U. of L. Microbiology Head to Assume Post July 1, 388

V

Variety to Keynote 1964 KSMA Annual Meeting September 29-October 1, 537

W

Ward, Donovan F., M.D., to Head AMA In '65-'66; Welch, Norman A., M.D., New President, 613
Welch, Norman A., M.D., AMA President, Dies During Wyoming Meeting, 790
Witten, Carroll L., M.D., New KAGP President, 464
Woman's Auxiliary Praised for Health Careers Work, 542

Y

Young, W. K., Named New Director of KSMA Field Services, 613

Whatever the methodology used and whoever the physi-cians who wish to participate in the testing of drugs, all of the groups that are concerned—should be vigilant to see that no one steps beyond his qualifications in testing a drug. And they, together with the Association of American Medical Colleges, should see that the problem of studying drugs in humans is placed squarely before medical students and house officers and that more opportunities are provided for them to observe the effects of drugs on people.—Harry F. Dowling, M.D., in *J.A.M.A.*, 187:3 (Jan. 18) 1964.

I have yet to see any desk-bound administrator or full-time politician who knows as much about the needs of a body as does the person who attends that body on an individual basis hour after hour. Concern and caution are advisable, of course, for all-drug maker, drug prescriber, drug dispenser and drug user. But when lay judgment is substituted for professional judgment, when the sick refuse to take what is wisely prescribed, when consumer representatives and motivation hunters try to resolve medical problems without medical knowledge when the medical profession is notified of government interventions in drug use through the popular press rather than through normal professional channels, when the public received medical information about drug reactions before the profession is informed, the already ailing members of the public will suffer even more. In fact, they will suffer more than any other group since it will be their own bodies which are deprived of needed medical counseling and remedies. Austin Smith, M.D., in *Oklahoma Medical Journal*, 57: 8 (August) 1964.

With all the progress that has been made, much remains to be done. Medical research is still almost impotent against multiple sclerosis, cystic fibrosis, mongolism, muscular dystrophy and many other conditions. Fortnately, medical progress is being carried forward by contributions of basic knowledge by men and women in the life sciences. Indeed, all the life and social sciences are now being brought to bear on the control of disease and its consequences. There is every reason for confidence that the enemies of mankind's health will be overcome one by one in the future through the combined efforts of the entire medical team. The pharmaceutical industry anticipates with pride the part that it will play in the ultimate success.—Alfred E. Driscol, President, Warner-Lambert Pharmaceutical Company, in *New England Journal of Medicine*, 270: 6 (Feb. 6, 1964).

WHERE HAPPINESS IS SKILLFULLY ADMINISTERED

In Addition To Suitable Medical and Nursing Care for Chronic, Convalescent and Geriatric Patients . .

NEW CASTLE SANITARIUM
TELEPHONE 3621
NEW CASTLE, KY.

MEMBER:
National Geriatrics Society
American Hospital Association
American Nursing Home Association
Licensed and Approved by State of Ky.

Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

Adequate shade trees, ramps, also day room with abundance of flowers, television.

PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

Protected throughout with automatic fire detection and alarm system.

Cares for men or women, nursing or boarding care cases, bedridden or ambulatory. Admits some mildly senile, nervous and neurotic patients but accepts no alcoholics or drug addiction cases.

REASONABLE RATES

IRA O. WALLACE, Administrator

MARGARET KELLY, R. N., Director of Nurses



"Wonderful...haven't had opening in both nostrils for years"*

(clearly decongested with Dimetapp)

Dimetapp lets your "stuffed-up" patients *breathe easy again*. Each long-acting Extentab works hard for up to 10-12 hours clearing away stuffiness, turning off the drip, and unplugging congestion that accompanies upper respiratory conditions. Yet, patients seldom experience drowsiness or overstimulation. (A key to success: the Dimetapp formula.) Now that the "stuffy" season is here, keep dependable Dimetapp Extentabs on tap. They get the job done.

FOR NASAL DECONGESTION IN SINUSITIS, COLDS, U.R.I.

UP TO 10-12 HOURS' CLEAR BREATHING ON ONE TABLET

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; Phenylephrine HCl, 15 mg.; Phenylpropanolamine HCl, 15 mg.)

BRIEF SUMMARY: Indications: Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. **Side Effects:** In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. **Precautions:** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. **Contraindications:** Antihistamine sensitivity. Not recommended for use during pregnancy.

*Clinical report on file, Medical Department, A. H. Robins Co., Inc.

A. H. ROBINS CO., INC., RICHMOND 20, VA.

KENTUCKY MEDICAL ASSOCIATION

BOARD OF TRUSTEES—1964-1965

Officers

DELMAS M. CLARDY, 901½ South Main Street, Hopkinsville ..... President
EVERETT H. BAKER, 1169 Eastern Parkway, Louisville ..... President-Elect
GEORGE P. ARCHER, Prestonsburg ..... Immediate Past President
ROBERT W. LYKINS, Louisville ..... Vice President (Central)
HAROLD B. BARTON, Corbin ..... Vice President (Eastern)
KENNETH M. EBLEN, Henderson ..... Vice President (Western)
HENRY B. ASMAN, 1169 Eastern Parkway, Louisville ..... Secretary
KEITH P. SMITH, CORBIN ..... Treasurer
GARNETT J. SWEENEY, Liberty ..... Speaker—House of Delegates
GEORGE F. BROCKMAN, Greenville ..... Vice Speaker—House of Delegates
ROBERT PENNINGTON, London ..... Chairman of the Board of Trustees
DONALD CHATHAM, Shelbyville ..... Vice Chairman of the Board of Trustees

Delegates to the A.M.A.

J. THOMAS GIANNINI, 1169 Eastern Parkway, Louisville ..... Sept. 25, 1963-Dec. 31, 1964
CHARLES G. BRYANT, 1169 Eastern Parkway, Louisville (Alternate) Sept. 25, 1963-Dec. 31, 1964
JOHN C. QUERTERMOUS, M.D., Murray ..... Jan. 1, 1964-Dec. 31, 1965
WILLIAM W. HALL, M.D., Owensboro (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965
WYATT NORVELL, New Castle ..... Jan. 1, 1964-Dec. 31, 1965
CHARLES C. RUTLEDGE, M.D., Hazard (Alternate) ..... Jan. 1, 1964-Dec. 31, 1965

Trustees

First District ..... O. LEON HIGDON, 2515 Broadway, Paducah 1965
Second District ..... W. GERALD EDDS, Calhoun 1967
Third District ..... GABE A. PAYNE, JR., 141 Alumni Avenue, Hopkinsville 1965
Fourth District ..... DIXIE E. SNIDER, Springfield 1965
Fifth District ..... A. O. MILLER, 233 E. Gray Street, Louisville 1966
Sixth District ..... REX HAYES, Glasgow 1966
Seventh District ..... DONALD CHATHAM, Shelbyville 1967
Eighth District ..... W. DONALD JANNEY, 722 Scott Street, Covington 1966
Ninth District ..... MITCHEL B. DENHAM, Maysville 1967
Tenth District ..... DOUGLAS E. SCOTT, 2101 Nicholasville Road, Lexington 1967
Eleventh District ..... HUBERT C. JONES, Berea 1966
Twelfth District ..... THOMAS O. MEREDITH, Harrodsburg 1965
Thirteenth District ..... WALTER L. CAWOOD, Kings Daughters Hospital, Ashland 1967
Fourteenth District ..... WILLIAM C. HAMBLEY, Pikeville 1965
Fifteenth District ..... ROBERT PENNINGTON, London 1966

Buyers Guide

JOURNAL OF THE KMA BUYERS GUIDE FOR DECEMBER, 1964

Ames Company 1057
Burroughs Wellcome 1051
Chicago Medical Society 934
Coca-Cola Company 1038
The Keeley Institute 1052
Lederle Laboratories 921-931-935-1020-1021-1027-1036-1037
Eli Lilly & Company 936
Medical Protective Company 934
Wm. S. Merrell Company 926-927
Mt. Holly Nursing Home 1048
New Castle Sanitorium 1054
Parke, Davis & Company 916
A. H. Robins Company 922-923-1055
Roche Laboratories 1058
W. B. Saunders Company 917
G. D. Searle & Company 1019
Smith Kline & French 933
Southern Optical Company 1038
Veterans Administration 1048
Wallace Laboratories 925-928-929-1023
Winthrop Laboratories 919



"the same old story, doctor—indigestion"

The patient's complaint is indigestion...especially of intolerance to fried foods...aggravated by stress. You diagnose functional G.I. disturbance and associated stress...as manifested by flatulence, "nervous" indigestion and constipation. Prescribe

DECHOLIN-BB®

(Hydrocholeretic • Antispasmodic • Sedative, AMES)

Each Tablet Contains:

BUTABARBITAL SODIUM.....15 mg (¼ gr)
(Warning: May be habit forming) to ease nervous tension

DEHYDROCHOLIC ACID.....250 mg (3¾ gr)
to produce large volume of watery bile, hydrate the bowel contents and gently stimulate the intestinal mucosa

BELLADONNA EXTRACT.....10 mg (⅙ gr)
to reduce smooth-muscle hypertonus

Average adult dose: 1, or if needed, 2 tablets three times daily. *Precautions:* Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction. Caution drivers against possible drowsiness. *Side effects:* Dehydrocholic acid may cause transitory diarrhea; belladonna — blurred vision, dry mouth. *Contraindications:* Biliary tract obstruction, acute hepatitis, glaucoma, and prostatic hyperplasia. *Available through your regular supplier:* DECHOLIN-BB, bottles of 100 tablets. 72664

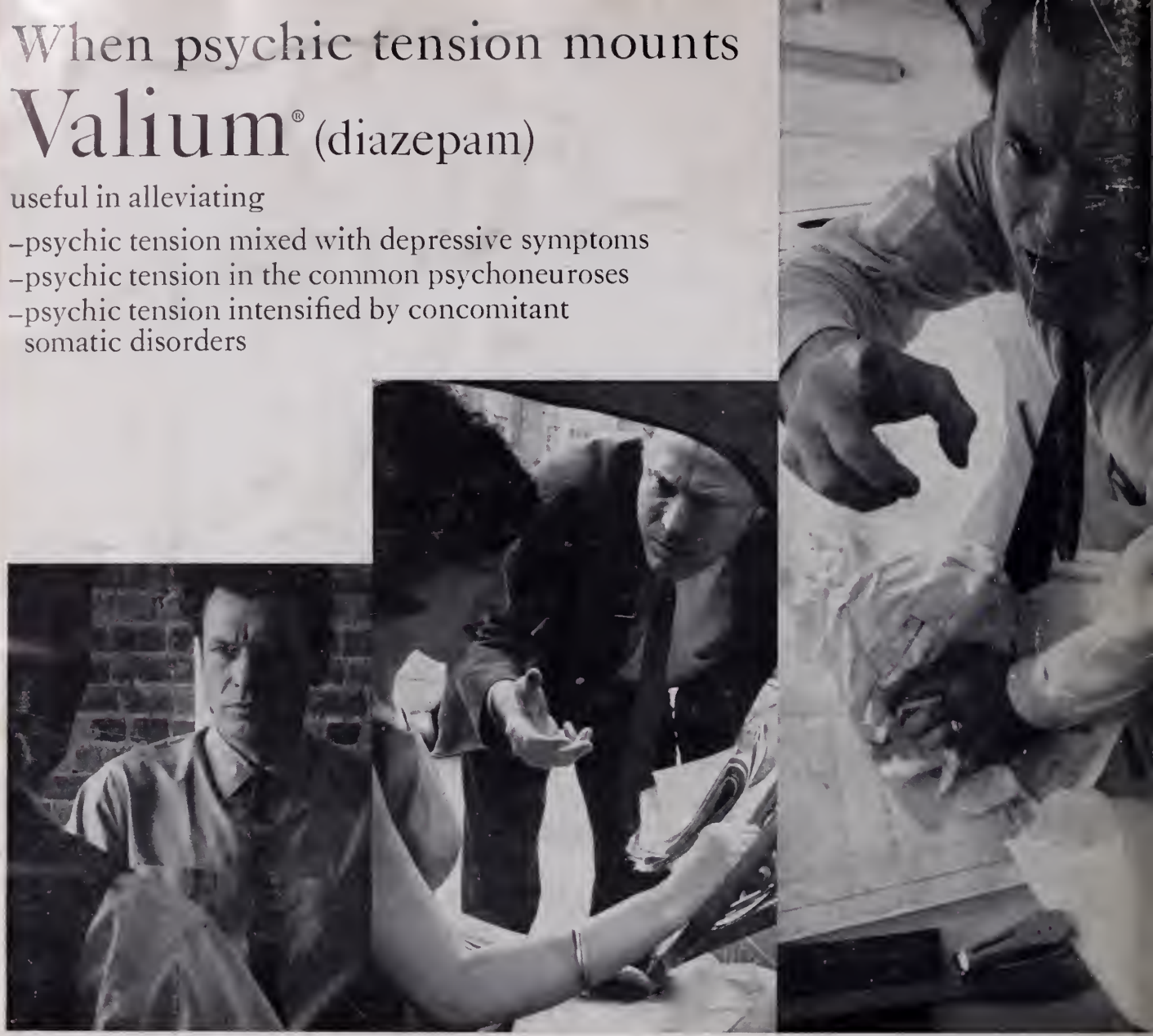
Ames Company, Inc., Elkhart, Indiana. AMES

When psychic tension mounts

Valium® (diazepam)

useful in alleviating

- –psychic tension mixed with depressive symptoms
- –psychic tension in the common psychoneuroses
- –psychic tension intensified by concomitant somatic disorders



How to prescribe Valium (diazepam)

Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue.

Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal.

Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in the treatment of psychotic patients, and for this reason should not be employed in lieu of appropriate treatment.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (e.g., convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

Valium (diazepam) is available as 5-mg and 2-mg tablets. For convenience and economy in prescribing, both strengths are supplied in bottles of 50.

Roche Laboratories endorses the principle of caution in the administration of any therapeutic agent to pregnant patients.

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

This Book is due on the last date stamped below. **No further preliminary notice will be sent.** Requests for renewals must be made on or before the date of expiration.

DUE	DUE
JUL 14 1967	
MAR 13 1968	
AUG 13 1968	
JUN 18 1974	

A fine of twenty-five cents will be charged for each week or fraction of a week the book is retained without the Library's authorization.